KELSEY TRAIL
HEALTH REGION

Annual Report to the Minister of Health

For the 2013-14 Fiscal Year Ended March 31, 2014













This Week's
$54


Table of Contents

The Kelsey Trail Health Region Annual Report for the fiscal year ending March 31, 2014 is available on the internet at www.kelseytrailhealth.ca.

Kelsey Trail Health Region is the operating name for the Kelsey Trail Regional Health Authority. Most references to this organization use Health Region, except in reference to the governing board, which is referred to as the Regional Health Authority. Health Region also refers to the geographic areas served by the Kelsey Trail Health Region.

Letter of Transmittal

May 28, 2014

Honourable Dustin Duncan
Minister of Health

Dear Minister Duncan:

The Kelsey Trail Regional Health Authority is pleased to provide you and the residents of the health region with its 2013-14 annual report. This report provides the audited financial statements and outlines activities and accomplishments of the region for the year ended March 31, 2014.

The Kelsey Trail Regional Health Authority is pleased to report several accomplishments during the 2013-14 fiscal year including:

- participation in a three year clinical pilot and feasibility study for chronic low back disorders;
- improved treatment for young surgical dental patients as the result of the addition of a new digital dental x-ray unit for the Nipawin Hospital surgical suite;
- completion of the second phase of the long term care replacement project in Tisdale; and
- implementation of Electronic Medical Records (EMR) for all physicians in the health region.

The overall success of the health region can be attributed to the compassion, dedication and commitment of the Kelsey Trail Health Region's greatest resource – its people.

Respectfully submitted,

Rennie Harper
Chairperson
Kelsey Trail Regional Health Authority

Introduction

The 2013-14 annual report presents the RHA's activities and the results of strategies, actions and performance measures identified within the provincial 2013-14 Health System Plan for the fiscal year ended March 31, 2014. This report demonstrates the health region's progress toward meeting 2013-14 targets and commitments, providing an opportunity to assess accomplishments, results and lessons learned while identifying how to improve on previous successes for the benefit of the residents of the health region.

Under Section 55 of *The Regional Health Services Act*, the Kelsey Trail Regional Health Authority (KTRHA) is legislatively required to report on its annual activities. The Authority is collectively responsible for leading the organization in determining, monitoring and assuring appropriate organizational performance. The annual report provides accountability for the activities of the KTRHA to residents and the Ministry of Health.

The information in the annual report is driven by standards, best practise, performance measures and indicators, outcome benchmarks, statistical and environmental data collected by a variety of credible provincial and national organizations and bodies by which the overall performance of health care services and programs are measured. The CEO is accountable for the financial administration and operational control of the health region and is confident the information contained within the annual report is accurate and complete.

Alignment with Strategic Direction

The health region's Vision, Mission and Values reflect the overall direction of the health system. The regional values are aligned with the provincial values of Accountability, Transparency, Respect, Excellence and Engagement.

The 2013-14 Health System Plan represents the second year of Hoshin Kanri, which features a collaborative approach to determine and achieve strategic priorities through engagement of all levels of staff in a process referred to as "catchball". The establishment of a regional visibility wall and monthly wall walks assist in measuring, reporting and identifying barriers to achieving regional goals and targets. Corrective action plans are developed to address issues that may impact success. Visibility walls and weekly huddles at the facility and departmental level include metrics that are meaningful to frontline staff while supporting regional targets and goals. Provincial priorities are focused on the 100 Year Strategies: Better Health, Better, Care Better Teams and Better Value which are based on the Institute for Healthcare Improvement's (IHI) Triple Aim. The 2013-14 health system priorities also support targets identified in The Saskatchewan Plan for Growth – Vision 2020 and Beyond.

Through the evolution of the Hoshin Kanri process, some of the provincial five year outcomes identified in 2012-13 were revised in 2013-14. Three provincial Hoshins - areas for breakthrough improvement over a 12 to 18 month period - were identified in 2013-14. Provincial breakthrough initiatives influence and guide the strategic priorities of the health region and impact achievement of the provincial three to five year outcomes.

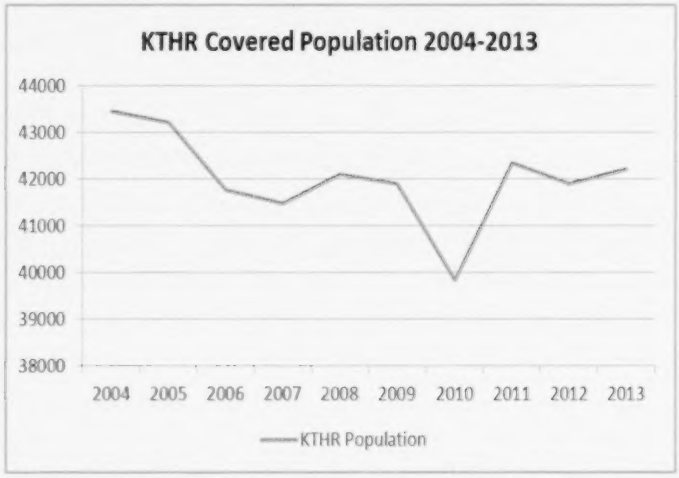
The *2013-14 Accountability Document* issued annually by the Ministry of Health clarifies the priorities, expectations and reporting requirements of the Regional Health Authority. It complements existing legislation, regulations, contracts, ministerial directives and policies, and establishes expectations based on targets set in the provincial *2013-14 Health System Plan*. Regional strategic planning is influenced and impacted by financial, operational, capital and human resources.

A commitment to a culture of safety, patient and family-centred care, continuous improvement and thinking and acting as one are the foundations upon which all provincial and regional health system planning are based. Supporting provincial documents such as the Patient & Family Centred Care (PFCC) Framework, For Patient's Sake – Patient First Review Commissioner's Report to the Saskatchewan Minister of Health, the Saskatchewan Surgical Initiative (SKSI) Plan, the Primary Health Care Framework, the HIV Strategy, as well as the standards set by Accreditation Canada, the Canadian Standards Association (CSA) and *SaferHealthcareNow!* (SHN) also shape strategic priorities.

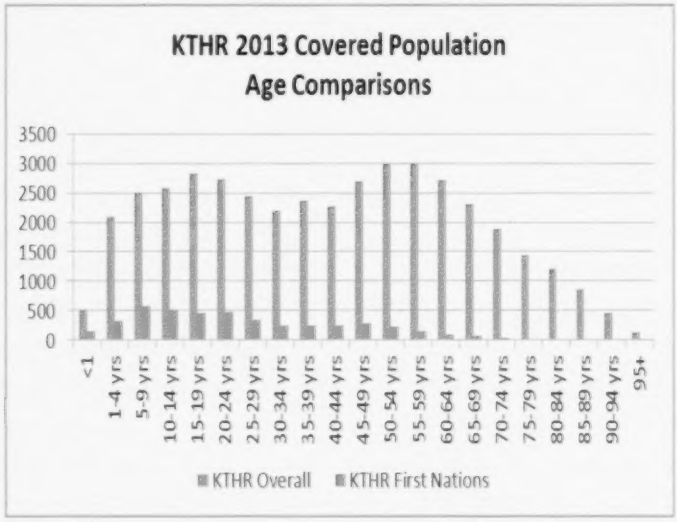
Overview

The RHA is responsible for providing safe, quality, timely, effective and efficient primary and secondary health care services to the population of the region. Services are available and accessible to residents as reasonably close to home as possible. At 44,369.62 square kilometres, the large geographic area of the region and the relatively sparse population pose challenges in achieving this goal.

According to 2013 Covered Population statistics, the total population of the region is 42,218, a slight increase over the previous year. The First Nations population (4,499) represents 10.66% of the region's total population. Only residents registered for provincial health coverage are included in the Covered Population, which may not include everyone who is a resident of the province as of June 30th. At 1.85 persons per square kilometre, the provincial population density is almost twice that of KTHR (0.94 persons per square kilometre).



Source: *Ministry of Health 2013 Covered Population*



Source: *Ministry of Health 2013 Covered Population*

Health services are provided to the residents of 58 rural and urban municipalities, five First Nation communities and the Northern Village of Cumberland House. In some cases, services to First Nation communities are delivered by KTHR in partnership with other agencies. Services not available within the region are accessible and available to residents through visiting specialists, referrals and the Telehealth Saskatchewan network.

Over 30 physicians and 1,600 staff provide a broad range of community and facility-based services and programs. Physician resources include a Chief of Staff/Vice-President of Medical Services, a Medical Health Officer, a resident General Surgeon, a visiting Radiologist, General Practitioner /Anaesthetists, and General Practitioner/Obstetricians.

The region ensures a wide range of accessible itinerant services by granting visiting privileges to a number of physician specialists at district hospitals in Melfort, Nipawin and Tisdale. Associate privileges are also granted to dental and chiropractic service providers.

Visiting Specialist Services
Ear/Nose/Throat
Obstetrics/Gynecology
Ophthalmology ♦ Orthopedics
Pediatrics ♦ Plastic Surgery
Podiatry ♦ Psychiatry
Urology ♦ General Surgery
Respiratory Medicine
Exercise Stress Testing

In total, 116 acute care beds (observation, respite, palliative, convalescent and rehabilitation) are staffed and operational within district and community hospitals in the region. Laboratory and x-ray services are available in the district and community hospitals. Lab services are also available at all four health centres. Carrot River is the only health centre with x-ray services. Radiology services have been discontinued at the other health centres over the past few years due to low volumes, the availability of digital imaging and the provincial Picture Archiving & Communication System (PACS) at neighbouring hospitals. In total, 482 long term care and respite beds are staffed and operational in ten facilities within the region. There are also four Dementia units operational within KTHR long term care facilities.

District Hospitals
Melfort ♦ Nipawin ♦ Tisdale
Community Hospitals
Hudson Bay ♦ Kelvington ♦ Porcupine Plain
Health Centres
Arborfield ♦ Carrot River ♦ Cumberland House ♦ Rose Valley ♦ Smeaton
Long Term Care Facilities
Arborfield ♦ Carrot River ♦ Hudson Bay ♦ Kelvington ♦ Melfort Nipawin ♦ Porcupine Plain ♦ St. Brieux ♦ Tisdale (2)

Pre-hospital emergency care is available through a combination of RHA-owned and contracted emergency medical services. Trained volunteer First Responders and Ancillary First Responder groups provide emergency services to a large number of communities and areas in Kelsey Trail. The region provides training to volunteers in community groups, organizations, schools and corporations who have invested in Public Access Defibrillators (PADs).

Primary Health Care Sites

Arborfield/Carrot River
Cumberland House
Hudson Bay ♦ Kelvington
Naicam ♦ Nipawin
Porcupine Plain ♦ Tisdale

Primary Health Care (PHC) services are delivered to more than 30 locations in the region by Physicians and NPs working collaboratively in teams with other health care professionals including Nutritionists, Speech/Language Pathology, Early Childhood Psychology, Dental Health, Dietitians and Nurse Educators, Chronic Disease Management, Community Wellness Coordinators, and Therapies, which includes an Autism Spectrum Disorder consultant, the Acquired Brain Injury program, Exercise Therapists, Recreation Therapists, Physical and Occupational Therapists. In total, 80.53% of the population has access to PHC services.

Employees of Community and Primary Health Care focus on community development and population health promotion. Services are delivered by Home Care, Public Health, Environmental Health, Therapies and Mental Health & Addiction. Public Health includes Public Health Nursing, Travel Health, the regional Medical Health Officer and Communicable Disease/Immunization Coordinator. Public Health Inspection, tobacco enforcement and water monitoring services are delivered regionally by Environmental Health staff.

Mental Health & Addiction Services (MHAS) are provided regionally through a combination of community-based locations and visiting services. Medical Social Worker services are also available through MHAS.

The region has a well-established Saskatchewan Telehealth video conferencing program which provides a link for rural and urban health care professionals to schedule specialist appointments, consults, clinical visits and follow-up appointments for patients and clients. It is also used for educational sessions for health care professionals and members of the public.

Volunteer services are coordinated through the Human Resources (HR) department and include the parent mentoring program, pastoral care, youth programs, gift shops, meals on wheels, auxiliaries, drivers and activity volunteers. Volunteers provide countless hours of service to the region every fiscal year.

Community Based Organizations

The region acts as the accountable partner in contractual relationships with a number of independent Community-Based Organizations (CBOs) and third parties for the delivery of health care services. CBOs are prescribed organizations that receive funding from KTHR to provide health services. The region is responsible for financial monitoring, ensuring adequate resources are being provided, and accountability among CBOs.

KTHR has contractual relationships with:

- Kelvington Ambulance Care Ltd., Tisdale Ambulance Care Ltd., Shamrock Ambulance Care Inc. (Rose Valley Division), North East EMS (Nipawin & Carrot River) and Melfort Ambulance Service Care (1999) Ltd. – emergency medical/ambulance services operating in the boundaries of the health region; and
- Nipawin Oasis Community Centre Cooperative - services for clients with long term mental illness in the Nipawin area.

Partnerships

Kelsey Trail has developed a number of mutually beneficial partnerships that provide strong connections to community, enhance resource-sharing opportunities and have long term impact on meeting the needs of the population.

Ministry of Health
The region's most significant stakeholder, the Ministry provides strategic and policy direction, sets and monitors standards, provides funding, and supports the health region to ensure the provision of essential and appropriate services to residents.

Health Shared Services Saskatchewan (3sHealth)
3SHealth provides select administrative and support services through a shared services model, including payroll and group benefits administration and contract administration for group purchasing.

Saskatchewan Association of Healthcare Organizations (SAHO)
SAHO provides labour relations services, including collective bargaining, as the representative employers' organization.

Prince Albert Parkland Health Region (PAPHR)/Sunrise Health Region (SHR)
KTHR has a partnership with PAPHR for the provision of mental health inpatient services, 24-hour emergency mental health referrals and consultations, specialty mental health services such as psychiatry, eating disorders and psychologist supervision as well as the delivery of orthopaedic surgical services at Nipawin Hospital. The region also partners with PAPHR and Sunrise Health Region on the F.A.S.T. Stroke Bypass Protocol. More recently, KTHR has partnered with PAPHR to supplement the regional delivery of biomedical engineering technology services.

Athabasca Health Authority (AHA)
A partnership with AHA has resulted in the provision of Information Technology support to the northern health region. Through the partnership, AHA has also benefitted from the

development and launch of the regional Radiography Information System-Picture Archiving Communication System (RIS-PACS) for the secure storage and retrieval of diagnostic images in digital format.

Saskatoon Health Region
A partnership with Saskatoon Health Region has resulted in the provision of Privacy support and services to KTHR by the Saskatoon Health Region's Privacy & Access Office.

North East Regional Intersectoral Committee (NERIC)
The health region is an active partner on the NERIC which includes representation from the North East School Division, Cumberland College, the Ministry of Social Services, Métis Nation Eastern Region 1 & 2, and several other human resource agencies. Through this partnership, the region facilitates and supports community-based approaches and initiatives in response to the needs of children, youth and families.

KidsFirst
KTHR is the accountable partner for the *KidsFirst* targeted program in Nipawin and non-targeted regional program. *KidsFirst* is a voluntary program that works in collaboration with existing community programs to help vulnerable families, enhancing knowledge, providing support and building on family strengths.

Nipawin Community Mobilization Unit – Nipawin Hub
In March 2013, KTHR partnered with the North East School Division, Ministry of Social Services, Ministry of Justice, Nechapanuk Child and Family Services, Town of Nipawin, Northeast Regional Intersectoral Committee and the RCMP to develop the Nipawin Community Mobilization Initiative - Nipawin Hub, a multi-agency collaboration focused on reducing crime and victimization and supporting a safer, healthier community. The Community Mobilization – Nipawin Hub approach is modeled after the Prince Albert Community Mobilization Program and is supported by the Government of Saskatchewan's Building Partnerships to Reduce Crime initiative (BPRC).

Saskatchewan Cancer Agency/Saskatchewan Heart & Stroke Foundation
In partnership with the SCA, KTHR operates the Screening Program for Colorectal Cancer which targets men and women between 50 and 74 years of age who are at risk of developing colorectal cancer. The SCA also has a unique partnership with the region as a sitting member of the KTHR PHC Population Health team and the region's Eat Well, Play Well group. The Saskatchewan Heart & Stroke Foundation is also represented on the KTHR PHC Population Health team, the Eat Well, Play Well group, the region's Tobacco Working Group and Healthy Weights Working Group.

Cumberland College/Saskatchewan Institute of Applied Science & Technology (SIAST)/ University of Saskatchewan

KTHR partners with all three educational institutions to provide practicum opportunities for post-secondary students in health-related fields to meet their educational needs.

Union Affiliates

In addition to the Saskatchewan Union of Nurses (SUN), KTHR has developed a respectful partnership with the Health Sciences Association of Saskatchewan (HSAS) and the Saskatchewan Government & General Employees Union (SGEU).

Municipal Stakeholders

The health region regularly partners with municipal bodies to address program and service needs. The health region is currently working in partnership with the Town of Kelvington, Town of Tisdale and surrounding municipalities on two capital projects. In Tisdale, the health region is also involved in a partnership with the Town in the development of a community health complex.

Other significant partnerships include community foundation and trust committees and auxiliaries, Health Quality Council (HQC), Prince Albert Grand Council, Saskatoon Tribal Council, Métis Nation Eastern Region 1 & 2, Lakeland District Sport Culture & Recreation and North Sask Laundry & Support Services.

Administrative Structure

The Chief Executive Officer (CEO) works with an Executive Management Team that includes the Vice-President Institutional & Emergency Care, the Vice-President Corporate Services, the Vice-President Community & Primary Health Care and the Vice-President Medical Services/Chief of Staff. The Executive Assistant to the CEO and Corporate Communications Officer serve as resources to the Executive Management Team.

Following the resignation of the CEO in December 2013, the Vice President Corporate Services was appointed acting Chief Operating Officer (COO) on an interim basis while the RHA worked to recruit the services of a permanent CEO.

The CEO reports directly to the RHA regarding the general and daily operations of the health region. The Executive Management Team is responsible for effective planning, integration and delivery of facility-based and community-based programs and services and reports directly to the CEO. The Executive Management Team is also responsible for the overall operation of the health region. Communication with the Management Network (regional directors, facility administrators, program and nursing managers) occurs through a combination of teleconferences and face-to-face meetings.

Within senior leadership, in April 2013 the role of the Director Building Services was shifted to fulfill the requirements of the Director Capital Projects to include, but not limited to, project management for the capital projects in Tisdale and Kelvington. As a result, the portfolio of the Director Materials Management was expanded to include Building Services. In addition, the role of the Director Food & Nutrition Services was expanded to include the additional role of Director Environmental & Laundry Services until December 2013 in order to complete the work required to combine the portfolios of Food & Nutrition Services and Environmental & Laundry Services under the umbrella of Director Support Services.

In August 2013, KTHR formally announced the establishment and structure of the Kaizen Promotion Office (KPO), formerly known as the Quality department. The change in structure resulted in a change in the titles of several members of the Quality department to reflect their new roles in the KPO including the change in title of the Director Quality to Director KPO. The restructuring helped align the KTHR KPO with the KPOs in other health regions across the province, an important step in strengthening and supporting the region as it continues on its lean journey.

At the management level, the Facility Administrator position at Carrot River Health Centre was expanded to also include the role of Facility Administrator of the Arborfield & District Health Care Centre.

Governance

The Kelsey Trail Regional Health Authority (KTRHA) includes nine members: chairperson Rennie Harper of Nipawin; vice-chairperson Clarence Hendrickson of Carrot River; Gordon Cresswell of Tisdale; Frank Garchinski of Naicam; Dennis Koch of Melfort; Kathleen Bedard of St. Brieux; and Darrel Guy of Lintlaw, Richard Radom of Kelvington and Nancy Steinbachs of Hudson Bay.

The RHA is responsible for the planning, organization, delivery and evaluation of the health services it is directed to provide by the Ministry of Health. The RHA functions primarily as a "committee of the whole". There are four committees of the RHA: Quality Risk Management & Communications Committee, Finance & Audit Committee, Practitioner Liaison Committee, and the Governance Committee.

The Regional Health Services Act requires each Authority to develop a process where public input and feedback is solicited to provide the Authority with advice respecting the provision of health services in the Health Region. These opportunities provide information on issues related to the health of the community and help the Authority to better understand the needs and priorities of communities and their residents. KTHR utilized five Community Health Advisory Networks (CHANs) in the past however, they have been largely inactive.

The Authority has successfully utilized a broad range of informal consultations to gather information on community issues, needs and priorities related to healthcare. In addition to existing intersectoral partnerships and relationships, the RHA and Executive have taken advantage of opportunities to meet with representatives of municipal councils and First Nations chiefs and councils to discuss health care concerns. During the fiscal year, there has been extensive consultation with groups of municipal councils and community champions in relation to the ongoing planning of capital projects at Kelvington and Tisdale. Other informal consultation has involved discussions with the NERIC, community stakeholder groups, neighbouring school divisions, health region foundation and trust committees, and auxiliaries.

The health region utilizes a variety of formats to communicate with and engage the public. These include regular monthly RHA meetings; community wellness assessments and other community-based events and activities; the external newsletter, the *KTHR Pulse;* the internal newsletter, *Coffee Break Conversation;* other publications including *Spotlight on Dental Health*, the *Primary Health Care Principle*, the *Volunteer Advantage* and *Hypertension Highlights* and several early childhood publications; the public website (www.kelseytrailhealth.ca); nine weekly and two regional, weekly newspapers; two community newsletters; and five radio stations. Regular contact with stakeholders and partners is maintained through a combination of email and regular mail distribution of publications. The RHA chairperson, CEO and other designated representatives are involved in presentations to municipal councils, community groups, partner agencies, community trust committees and/or foundations and the general public.

The KTHR Annual Report is produced and available in hard copy format and electronically through the region's website at www.kelseytrailheath.ca.

Employee Demographics

The KTHR workforce includes 1,639 total employees representing 1,062.45 full-time equivalents (FTEs). Of those, 21.5% are casual. In total, almost 42% of the regional workforce is 50 years or older. The regional workforce is comprised of approximately 92% females. Seventy-four, or 6.2% of the region's FTEs have self-identified as Aboriginal since 2007-08.

A significant percentage of KTHR employees are long term. Fifty-two employees retired in 2013-14. In total, 184 current employees reached Rule of 80 retirement eligibility as of March 31, 2014. By March 31, 2017, an additional 128 employees will reach Rule of 80 retirement eligibility.

The single largest challenge the region faces is recruitment and retention. The region experiences difficulty in recruiting and retaining Registered Nurses, Nurse Practitioners, Continuing Care Aides (CCAs), Therapists (occupational and physiotherapy), Pharmacists, and Lab and Diagnostic Imaging technicians. Labour shortages in any of these areas have the potential to impact patient, client and resident care.

While the recruitment of Family Physicians has been challenging in the past, in 2013-14 physician resources in KTHR began to stabilize. The health region gained seven new physicians and lost five during the course of the year. The recruitment and retention of General Practitioner/Obstetricians and General Practitioner/Anaesthetists continues to be somewhat challenging and can impact the region's ability to provide labour and delivery services and deliver surgical services.

Emerging Health Issues

The health region works collaboratively with the Ministry of Health and Health Canada to maintain an awareness of emerging health issues. They are identified and addressed on the basis of priority.

Populations lacking or having difficulty accessing one of more of the determinants of health may be subject to disparities in health. Within KTHR, many people face challenges in accessing the resources that help achieve physical, mental and social well-being and directly impact overall health.

Adequate housing and food security are key determinants of health and the overall well-being of the population. The Northeast Housing Research Project revealed a shortage of affordable rental stock and waiting lists in Melfort, Nipawin and Tisdale.

Food security issues may result in poor diet choices that can contribute to higher rates of diabetes and obesity. According to The Cost of Healthy Eating in Saskatchewan 2012, a report by the Saskatchewan

Determinants of Health

- *Income*
- *Social Support*
- *Education & Literacy*
- *Employment & Working Conditions*
- *Social Environments*
- *Physical Environments*
- *Personal Health Practices & Coping Skills*
- *Healthy Child Development*
- *Biology & Genetic Endowment*
- *Health Services*
- *Gender & Culture*

Health Canada

Food Costing Task Group, many factors influence individual ability to make healthy food choices including economic and social factors, coping skills, environment, working conditions and geography. In KTHR, many people must travel long distances to access healthy foods.

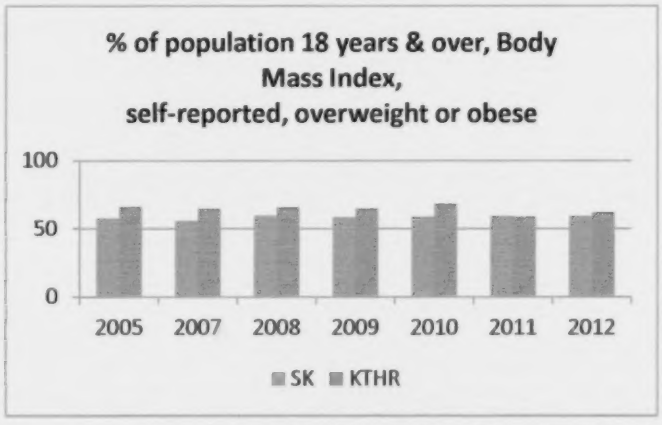
The report indicates the cost of the National Nutritious Food Basket for a reference family of four was $944.99 per month provincially and $922.13 in KTHR. Monthly food costs for residents living in urban areas (Melfort and Nipawin) were lower than the provincial and regional average at $861.41 per month while those living in rural areas paid slightly more than both the provincial and regional average at $947.36 per month. Food costs are highest in northern Saskatchewan.

Grocery stores are not available in many rural communities and First Nation reserves which may result in some residents relying on food available at gas stations, convenience stores or local general stores. In KTHR, food security issues are partially addressed with the aid of nutrition policies in schools, seasonal farmer's markets and Good Food Box programs.

According to the Indigenous Peoples' Health Research Centre, Aboriginal communities have identified their priority concerns as socio-economic status; mental health and addictions/trauma; and chronic disease – high rates of smoking and diabetes.

KTHR Primary Health Care Provider Teams conducted Community Wellness Assessments in the communities of Arborfield, Carrot River, the Northern Village of Cumberland House, Hudson Bay, Kelvington, Naicam, Nipawin, Porcupine Plain and Tisdale in 2013. The cumulative results of these assessments indicate the health concerns of residents living in these communities are similar to those living in Aboriginal communities and include adult overweight/obesity, cancer, heart disease and stroke, diabetes and mental health.

According to data from the Ministry of Health, Epidemiology and Research Unit, Population Health Branch, chronic conditions can be risk factors for one another. The presence of chronic conditions such as diabetes and hypertension increases the risk for another by about three times. The risk of chronic disease is also influenced by other factors such as smoking, obesity and physical inactivity. Many of the health

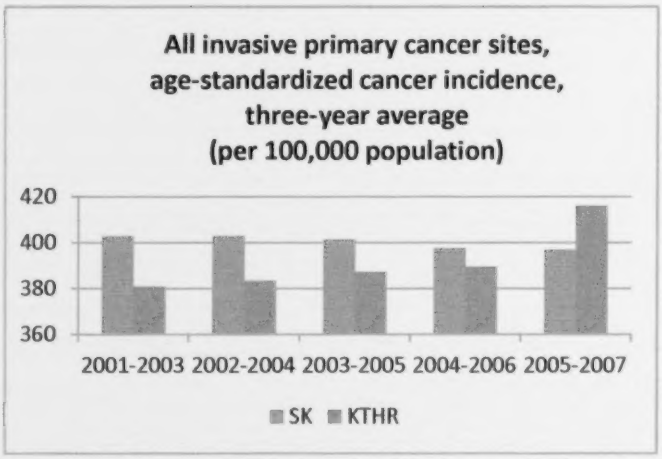


Source: Statistics Canada Health Profile December 2013

concerns identified in KTHR are linked to the high rates of co-morbidity among chronic conditions in KTHR as well as higher rates of other contributing risk factors.

Data from the Statistics Canada Health Profile, December 2013 indicates 61.7% of the population aged 18 and over has a self-reported Body Mass Index (BMI) that is considered overweight or obese as compared to 56.9% provincially. A larger percentage of males (71.2%) than females (52.6%) are considered overweight or obese in the region. In KTHR, 32.0% of the population 18 years and over reports a BMI that is considered obese (30 or greater). Provincially, 25.4% report a BMI considered obese. BMI is a method of classifying body weight according to health risk. Higher health risks are associated with obesity which can be linked to chronic diseases like hypertension, type II diabetes, cardiovascular disease, osteoarthritis and certain types of cancer.

The KTHR cancer incidence for all primary invasive cancer sites has increased by more than 14% between 2001-03 and 2005-07. Provincially, it has decreased by 1.5% over the same period.



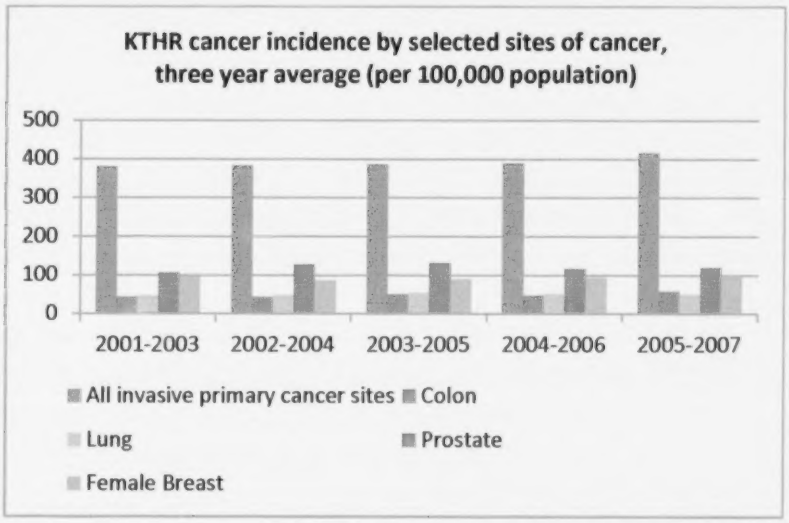
Source: Statistics Canada, Canadian Cancer Registry (CCR) Database (July 2011 file) and Demography Division (population estimates)

At 416.1 per 100,000 population, the cancer incidence in KTHR is higher than the provincial rate of 396.8 per 100,000. Cancer incidence among males in KTHR is slightly lower than the provincial rate while the incidence rate of 383.5 per 100,000 for females is greater than the provincial rate of 348.5 per 100,000.

The Saskatchewan Cancer Control Report: Profiling Cancer in Regional Health Authorities reports KTHR's five year invasive cancer prevalence rate of 15.5 per 1,000 population is higher than the provincial rate (13.5) and third highest in the province. The region's ten year prevalence rate is also higher than the provincial rate of 21.1 per 1,000 and, at 25 per 1,000 population, is the fourth highest in the province.

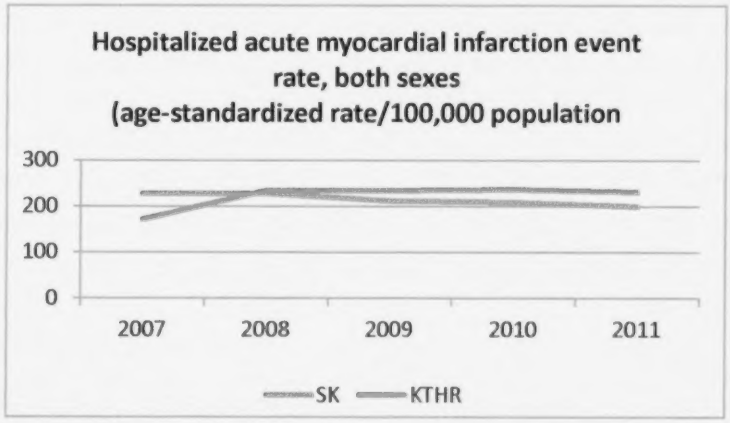
In KTHR, like Saskatchewan, lung cancer is the leading cause of cancer death, representing 24% of all cancer deaths in the province and 26% of all cancer deaths in the region. The second most common cause of cancer death in the province and region is breast cancer for females and prostate cancer for males. Colorectal cancer was the third most common cause of cancer death among both sexes.

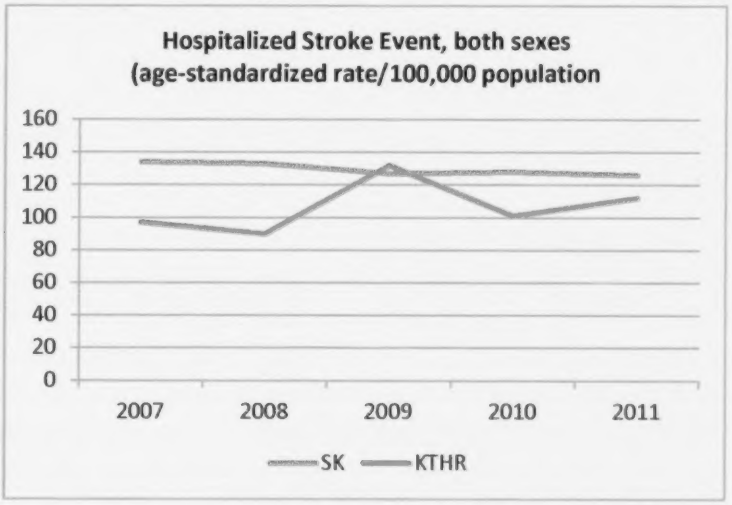
According to Canadian Cancer Statistics 2013, many factors influence the likelihood of developing cancer, including population demographics, the prevalence of risk factors like tobacco use or alcohol consumption, life expectancy and others. An increase in the growing and aging population also impacts the increase in the number of new cancer cases.



Source: Statistics Canada, Canadian Cancer Registry (CCR) Database

The Heart & Stroke Foundation of Saskatchewan defines cardiovascular diseases as diseases and injuries of the cardiovascular system: the heart, the blood vessels of the heart and the system of blood vessels (veins and arteries) throughout the body and within the brain. Stroke is the result of a blood flow problem in the brain. It is considered a form of cardiovascular disease.





At 28.4, the hypertension incidence in KTHR is higher than the provincial rate of 26.8 per 1,000. According to the Ministry of Health, Epidemiology and Research Unit, Population Health Branch, without treatment those diagnosed with hypertension can increase their

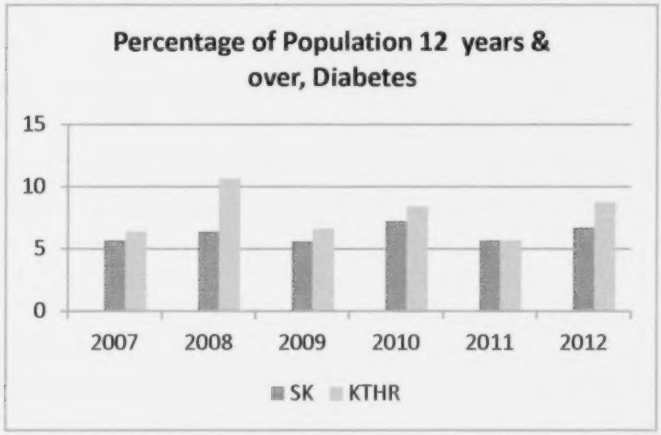
1996-2011, Canadian Institute for Health Information

risk of stroke, coronary heart disease, dementia, heart and kidney failure. In Saskatchewan, the prevalence of hypertension is elevated among those with diabetes and 71.3% of those with diabetes are also diagnosed with hypertension. The risk of complications associated with hypertension can be reduced by controlling blood pressure, with a healthy diet, exercise, weight loss, smoking cessation, reduced alcohol intake and medication.

Hospitalized acute myocardial infarction (AMI) is one of the leading causes of morbidity and death. KTHR has a higher rate of hospitalization for AMI's than the province at 232 compared to 200 per 100,000 provincially.

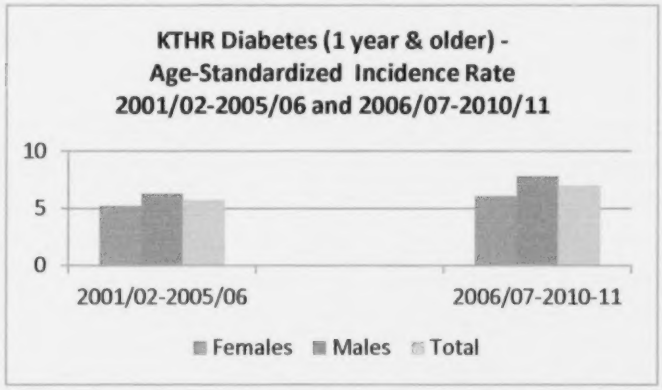
Stroke is one of the leading causes of long-term disability and death. KTHR's rate of hospitalized stroke events is slightly lower than the province at 112 per 100,000. The provincial rate is 126 per 100,000.

Diabetes can lead to a reduced quality of life and complications such as heart disease, stroke and kidney disease. Risks may be reduced by controlling blood sugar with a healthy diet, exercise, weight loss and medications.



Source: Public Health Agency of Canada, Chronic Disease Infobase

It is estimated more than half of type II diabetes cases could be delayed or prevented through healthier eating and increased physical activity. The Indigenous Peoples' Health Research Centre indicates an increase in diagnosis among First Nation and Métis populations and diagnosis appears to be occurring at a younger age. The prevalence of diabetes is elevated among those with hypertension.



Source: Saskatchewan Ministry of Health, Primary Health Care Services Branch

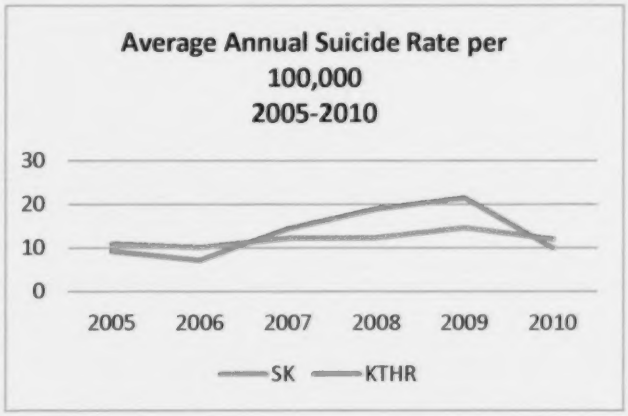
According to data from the Public Health Agency of Canada (PHAC), diabetes rates in KTHR have been steadily increasing since 2009. Provincial data from the Population Health Branch indicates a gradual increase in the age-standardized prevalence rates for diabetes (1 year & older) in the region since 2001-02. The

greatest increase has been in the prevalence of diabetes among males in KTHR, which has grown by 52% over the nine year period from 2001-02 to 2010-11. Over the same period, the prevalence rate for women has increased by 44% and the total regional prevalence rate has increased 50%.

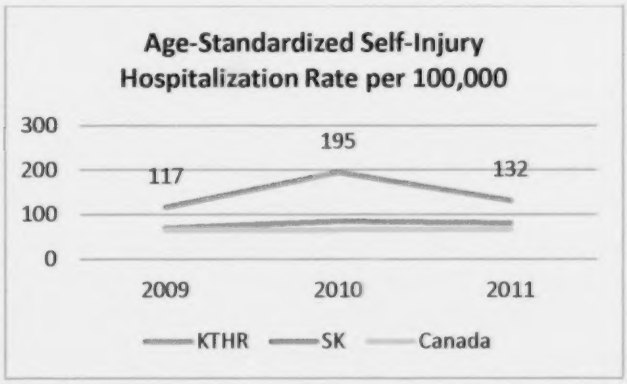
The age-standardized incidence rate of diabetes in those one year and older in KTHR has also increased. Data from the period 2001/02 – 2005/06 to 2006/07 – 2010/11 indicates an almost 23% increase in the region's total diabetes incidence rates from 5.7 in 2001/02 – 2005/06 to 7.0 per 1,000 in 2006/07-2010/11. During the same period, the incidence rates for males in KTHR increased almost 24% while the rate among females grew by 17%.

According to Population Health Branch data for the year ending March 31, 2011, KTHR has the third highest diabetes prevalence rate in the province at 69 per 1,000. The region's age-standardized diabetes incidence rate for the period 2006/07 to 2010-11 was fourth highest in the province at 70 and above the provincial incidence rate of 59 per 1,000. KTHR's Aboriginal population has an incidence rate twice as high as the provincial diabetes incidence rate. The prevalence of diabetes in the province and KTHR has gradually increased over the past ten years due to the fact that more people are being newly diagnosed with diabetes each year than are lost to death.

Suicide and attempted suicide rates continue to be a concern in Kelsey Trail Health Region. Data from the Canadian Institute for Health Information (CIHI) indicates the region's 2011-12 age-standardized self-injury hospitalization rate of 132 is almost twice as high as the national rate and over 48% greater than the provincial rate of 81 per 100,000. Self-injury hospitalization rates in Kelsey Trail are the second highest in the province. Though the regional self-injury hospitalization rate has decreased from the 2010-11 rate of 195 per 100,000, it continues to be very high. In 2010-11, the region had the highest rate of self-injury hospitalization in the province.



Source: eHealth Saskatchewan



Self-injury is deliberate bodily injury that may or may not result in death. This type

of injury is the result of either suicidal or self-harming behaviours, or both. Self-injury can be prevented, in many cases, by early recognition, intervention and treatment of mental illnesses. While some risk factors for self-injury are beyond the control of the health system, high rates of self-injury hospitalization can be interpreted as the result of a failure of the system to prevent self-injuries that are severe enough to require hospitalizations.

KTHR's average annual suicide rates between 2007 and 2011 were slightly higher than the provincial average. Suicide rates in northern Saskatchewan are almost double that of southern Saskatchewan, according to the 2012-13 Community Program Profile prepared by the provincial Ministry of Health's Community Care Branch.

Increasing care requirements for the aging population are also a concern in KTHR. The demand for home care services in KTHR is increasing in direct correlation to the increased medical and psychosocial complexity of clients. In KTHR, 43% of the region's population over the age of 75 received home care services in 2012-13, slightly more than the previous year. The highest proportion of home care clients are represented by those 80 to 89 years of age, similar to the province.

At 65.8, KTHR has the second highest average home care services per client ratio in the province and is significantly higher than the provincial average of 48.4, according to the Ministry of Health Community Care Branch's 2012-2013 Community Program Profile. Sixty-four percent of KTHR home care clients are considered either very high priority or high priority according to MAPLe tool evaluation, a decision support tool used to prioritize clients needing community or facility-based services. Clients' assigned very high priority are at high risk of adverse health outcomes. At the provincial level, 53% of home care clients fall in the same categories.

Acute care discharges and the provincial surgical mandate are both impacting home care demand and workload. KTHR has the least amount of Personal Care Home (PCH) beds in the province for the population aged 75+ at 6 per 1,000, more than seven times less than the provincial average of 45 per 1,000. Within the region, there are only two licensed personal care homes with the capacity to care for a total of 25 clients. This impacts home care utilization for clients that cannot be admitted into long term care. Staff continue to be challenged with increased incidents of behavioural problems, aggression, wound care, palliative care and planning for demanding care.

Progress in 2013-14

The Ministry of Health develops and issues an annual document clarifying the performance relationship between the Ministry and the health region. The *Accountability Document* is focused on strategic directions for the health region and the Ministry's expectations for the region, complementing existing legislation, regulations, contracts, Ministerial directives and policies. All assumptions and accountabilities within the *Accountability Document* are prepared within the strategic priorities as outlined in the *2013-14 Health System Plan*. Focusing on the 100 year strategies of better health, better care, better values and better teams, these areas of emphasis translate the region's vision, goals and priorities into a comprehensive set of performance measures and targets which provide a framework for achieving organizational improvement strategies directed at meeting the provincial three to five year outcomes as outlined in the *2013-14 Health System Plan*. The regional priorities identified through Hoshin Kanri also reflect commitments made in *Saskatchewan's Plan for Growth,* the *Speech from the Throne 2013* and the Minister's letter to the KTRHA Board Chairperson.

Better Health	**The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome to have people living with chronic conditions experience better health as indicated by a 30% decrease in hospital utilization related to six common chronic conditions (Diabetes, Coronary Artery Disease (CAD), Coronary Obstructive Pulmonary Disease (COPD), Depression, Congestive Heart Failure, Asthmas) by 2017.**

Improvement Target
By 2017, there will be a 50% improvement in the number of people who say "I can access my Primary Health Care (PHC) Team for care on my day of choice either in person, on the phone, or via other technology.

Provincial Hoshin: By March 2014, improve access and connectivity in PHC innovation sites and use early learnings to build foundational components for spread across the province.

KTHR Results:

KTHR Hoshin/Project #1: Kelvington & area 3P project

- The acute care facility in Kelvington was built in the 60s, is antiquated and does not currently allow for good patient or provider flow. The current model of care has evolved from institutional care to health prevention and a community-based approach to health care services.
- The existing long term care facility is functional but requires upgrades and renovations to increase resident and provider safety and improve infection control.
- Provincial funding has provided an opportunity to build onto the existing long term care facility and integrate acute, community and primary health care services with long term care.
- Following data collection at Kelvington Hospital January 14-18 and February 11-15, 2013, consultants from John Black & Associates (JBA) led a team of Kelvington staff, managers, patients/families and KTHR senior leaders through the 3P (Production Preparation Process) in March 2014 to formally begin the facility planning process.

Measurement Results:

By March 31, 2014, KTHR will have developed an integrated service delivery model to include access to acute care, primary health care, home care, long term care and same day access, with no disruptions in services

The Kelvington 3P met a number of milestones during the 2013-14 fiscal year which have had a positive impact on the ongoing progress of this project.

March 2013	April 2013	May 2013	July 2013	October 2013	January/February 2014	March 2014
3P event week	30 day review	RPIW #1 Event Week	60 day review	90 day review	33% design submission	66% design submission

The 3P team has applied 7 Flow/7 Wastes lean methodology and met with the project architects on many occasions to improve and enhance the project design. The design is approaching the 99% stage at which point it will be submitted to the Ministry of Health for approval. Funding commitments from the municipal partners are expected to be finalized early in the new fiscal year.

A 5S campaign involving the hospital and the long term care facility in Kelvington has eliminated waste, duplication, extra steps and created more efficient workspaces for staff which enhances service and care delivery for patients and residents which will be transferred into the efficient operation of the new facility.

Kelvington staff participated in two Rapid Process Improvement Workshop (RPIW) events. RPIW #1 focused on rerouting outpatients to the Primary Health Care clinic, when appropriate, and reducing wait times for patients in the clinic. During the RPIW, the team increased capacity in the clinic to meet demand and reduced the lead time for patient visits by 45%. At the 90 day audit, the team continued to hold their gains. Further improvement work is required to address the Canadian Triage & Acuity Scale (CTAS) 4/5 patients being redirected to the clinic.

RPIW #2 focused on reducing defects in discharge planning at Kelvington Hospital. During the RPIW, the team implemented discharge follow-up phone calls to patients to inquire if they were having trouble with their medications. The 90 day audit revealed the team has continued with the follow-up phone calls with few discharged patients indicating they are having trouble with their medication. The audit also revealed the team is making significant progress toward achieving 100% compliance with maintaining and updating discharge visibility boards in patient rooms and the nursing station.

The improvement work accomplished through the Kelvington 3P Hoshin will continue as daily work in 2014-15 and learnings from both RPIWs will be shared, applied to and support other lean quality improvement work throughout the region.

Improvement Target
By 2017, there will be a 50% improvement in the number of people who say "I can access my Primary Health Care (PHC) Team for care on my day of choice either in person, on the phone, or via other technology".

Results:

- In February 2014, with the support of the KPO and in cooperation with clinic staff, Primary Health Care was involved in Value Stream Mapping (VSM) at Primary Health Care clinics in Nipawin (2), Tisdale and Kelvington to assess the current state of clinic access for patients.
- Through the VSM process, baseline data for measuring same day access in its current state was collected for each clinic.
- From the patient's perspective, the percentage of value added processes (when the patient is receiving direct care or service that moves the care process forward) should be greater than the percentage of non-value added processes such as waiting, walking or driving to different locations to receive services, and duplication of services or processes such as registration.
- Cumulative value added time for all four clinics ranged from 11 to almost 26 minutes or 44-65%. Cumulative non-value added time ranged from six to 32 minutes or 34-55%.

Baseline data suggests there is an opportunity for improvement in same day access at all four clinics.

- Cumulative lead time, the average time it takes for one patient to go through the appointment process from start to finish, ranged from 11 to almost 26 minutes.
- Some of the challenges with receiving access on day of choice that were identified include clinics limiting appointment bookings to four weeks in advance, patients without primary providers, and multiple demands on physician schedules including ER call, satellite clinics, surgical assists, and anaesthetics and obstetrical call.

In the new fiscal year, current state VSMs will be completed and baseline data will be collected at the remaining PHC clinics in the region. The development of future state maps will be the next step in the improvement process. Through kaizen bursts, the clinics that have developed current state maps and baseline data identified opportunities for improvement work that revealed common themes.

Measurement Results:

Percent of patients who respond to a survey question that they can access their PHC team for care on their day of choice.

In November 2013, Primary Health Care patient experience surveying began in Arborfield, Carrot River, Cumberland House, Hudson Bay, Kelvington, Naicam, Nipawin, Porcupine Plain, Red Earth First Nation, Shoal Lake, Smeaton and Tisdale. Patients receiving primary health care services at these sites are asked to complete the survey at the conclusion of their visit. The survey goal is 20 per month per site.

Health Quality Council (HQC) houses the survey data and develops reports which are provided to clinicians, clinic groups and the health region. The data provided will be used to establish a baseline. The survey data is collected from patients that are able to access an appointment. This tool does not provide data on the number of people that call for an appointment.

Improvement Target
By 2017, 80% of patients are receiving care consistent with clinical practice guidelines for six common chronic conditions (Diabetes, CAD, COPD, Depression, Congestive Heart Failure, and Asthma).

Results:

Best practice guidelines for Diabetes and Coronary Artery Disease (CAD) are currently available to all KTHR Physicians, Nurse Practitioners and allied health providers via the Electronic Medical

Record Chronic Disease Management Quality Improvement Program (CDM QIP) templates. The templates have been rolled out to KTHR providers over the past six months. The CDM QIP is a partnership between the Saskatchewan Medical Association and the Ministry of Health.

During the upcoming year, KTHR will be able to establish the percent of patients that are receiving care consistent with these guidelines. Templates for the remaining four chronic conditions will be implemented next year.

Better Health

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome that by 2017, at risk populations (all age groups) will achieve better health through access to evidence based interventions, services and/or supports.

Improvement Target

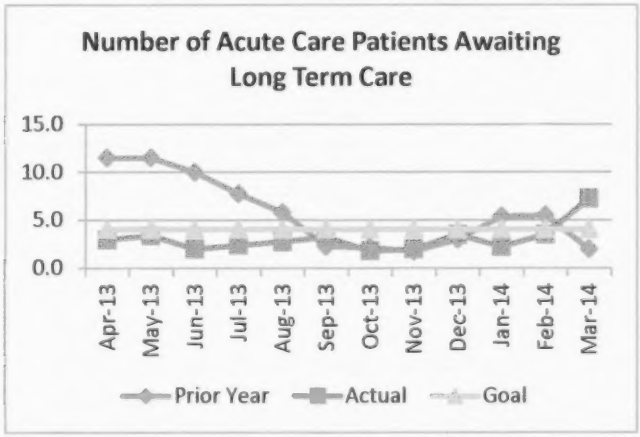
Reduce the number of patient days of seniors occupying acute care beds awaiting community service supports (i.e. Home Care) by 50% by March 31, 2017.

Results:

- KTHR achieved the 2013-14 target to have 3.5% or less (4.1 persons) of the total acute care beds occupied by clients awaiting long term care placement by March 31, 2014, achieving a fourth quarter running average of 3.3.

Measurement Results:

Number of acute beds occupied by long term care residents waiting placement.



Date Prepared: 04/17/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly

This number represents the average number of clients waiting for a long-term care placement in acute care beds. In KTHR, acute beds include medical, surgical, pediatric, obstetric, CCU, and other short term acute beds but does not include sub-acute and alternative level of care beds, including observation, respite, long term care, palliative care, rehab and other sub-acute beds. This measure only includes those clients who have been assessed and accepted for long-term care placement. It excludes

any other alternate level of care clients who are no longer in need of acute care services, but remain in acute care waiting to be discharged to another appropriate setting.

- KTHR successfully achieved and maintained a reduction in the number of clients occupying acute care beds while awaiting long term care placement.
- During 2012-13, the KTHR Access Review Committee (ARC) changed the manner in which clients awaiting long term care placement in acute care beds were addressed. Clients assessed as requiring long term care and receiving extensive care from family/caregivers or family/home care support equal to the home care maximum of approximately 30 hours per week are now immediately placed on the transfer list. This allows the client to be supported in home by family with home care "topping up" their care until a long term care bed becomes available.
- KTHR chose to change this aspect of the ARC process for several reasons:
    - to acknowledge the care being provided by families and the costs the region is not incurring as the result of this care;
    - to avoid duplication of work and the costs associated with being placed into the first available bed and then transferred;
    - to potentially decrease the home care workload, which can include maintaining the client at home by providing extensive services; and
    - to potentially decrease the number of Alternate Level of Care (ALC) days spent in hospital thereby decreasing the risk related to institutionalization for the individual while also increasing acute care bed availability.
- KTHR recognizes the potential risk associated with the change in the ARC process is an increased number of individuals on the transfer list.
- Strong emphasis is placed on discharge planning and timely assessments for patients awaiting long term care assessment and placement.
- The number of ALC clients assessed and accepted by the ARC is tracked weekly to ensure clients presented are deemed acceptable for permanent placement.
- Though acute care services and patients are not impacted by the number of individuals waiting for long term care in acute care in the district hospital setting, staff workload is.

There seems to be a trend of decreased client hours in home care related to the declining rural population, ongoing long term care vacancies (which have averaged around 12 over several months in 2013-14), changing demographics and a pressure to fill long term care beds. Individuals desiring long term care are required to be at a higher level of care however, it appears KTHR long term care is housing clients below the provincial average. Many of these clients could be cared for at home with additional community resources for staff and funding.

Improvement Target
By March 31, 2017, 100% of cases of specific communicable diseases human immunodeficiency virus (HIV), tuberculosis (TB), and sexually transmitted infections (STI) in high risk populations are managed according to provincial standards.

Results: **HIV**

- In 2013-14, for the second consecutive fiscal year, no new cases of HIV were reported in KTHR. In total, since 2004-05 KTHR has had eight reported HIV cases, ranging from zero to two new cases reported annually.
- Provincially, 177 new cases of HIV were reported in 2012, a five percent decrease from 2011.

Measurement Results:

Percent of HIV cases that are managed according to provincial standards

In KTHR, 100% of confirmed HIV cases are managed as per provincial and national standards. The Ministry Chronic Disease manual outlines follow-up and reporting procedures. HIV and AIDS forms are forwarded to the Ministry of Health when follow-up is complete.

- Epidemiology of HIV in Saskatchewan indicates an increasing trend of new HIV cases that are injection drug use-related.
- Since 2005, Aboriginal women have accounted for a disproportionate number of female HIV cases under the age of 30.
- There has been an increase in the number of HIV cases in males 30 years and older.

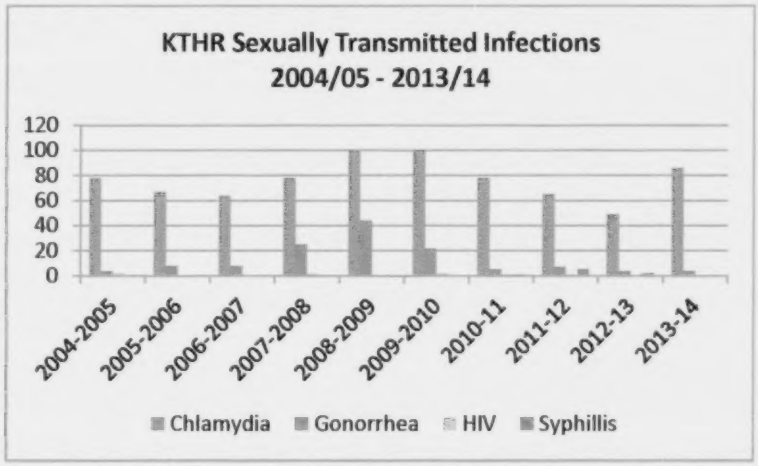
As part of Saskatchewan's HIV Strategy 2010-14 Update, the government committed annual provincial funding for community-based organizations, in collaboration with RHAs, to develop programs to assist in achieving goals outlined in the strategy. The Salvation Army (Melfort, Nipawin & Tisdale) received $3,000 in funding to support an HIV Awareness Support project. The project involved the distribution and display of HIV pamphlets and a workshop on HIV awareness to train Salvation Army staff to provide assistance with educating clients about HIV, make referrals, provide emotional support, transportation or health referral appointments.

Results: **Sexually Transmitted Infections (STI's)**

- The number of Sexually Transmitted Infections (STI's) reported in the region increased slightly but continues to be lower than peak periods in 2008-09 and 2009-10. While the region has not completed any scientific analysis, the 75.5% jump in the number of chlamydia cases since last year may be due to increased physician testing compared to

previous years or may be linked to social media, as was suggested by Saskatoon Health Region's deputy Medical Health Officer as part of the reason behind the increase in STI cases in that health region (Saskatoon Star Phoenix, April 17, 2014)

- Increased use of social media and smart phone dating apps among young people may result in involvement and short term relationships, practising safe sex less and a higher risk of the transmission of STI's.



Source: KTHR Communicable Disease/Immunization Coordinator 2013-14 Fiscal Year Report

- The rate of newly diagnosed cases of chlamydia has and continues to be the highest among all other reported STI's in the region, representing 95.5% of all STI's reported in KTHR in 2013-14.
- The number of lab positive gonorrhea cases remained the same as the previous year at four. There were no lab positive syphilis cases reported in 2013-14.
- The highest rate of lab positive STI's is in the 15 to 25 year age group. The 20-25 year age group has the highest rate of infection at 38 in 2013-14 with the 15-19 year age group following close behind at 33.

Measurement Results:

Clinics: Percent of individuals with a positive lab report for Chlamydia, Gonorrhea and Syphilis who are initiated on the recommended STI treatment within seven days of a positive lab report

KTHR does not qualify for an STI clinic due to the population of the region.

Overall for all STI Services: Percent of cases of Chlamydia, Gonorrhea, and Syphilis that have public health follow-up and Integrated Public Health Information System (iPHIS) case standing completed within two weeks of a positive lab report

In KTHR public health nursing only becomes involved in STI cases if a physician requests help with finding the index case or when public health needs to follow contacts if the index case and/or physician does not notify contacts. When public health nurses become involved, the public health standard to notify the contacts of an index case within two weeks is met.

The ability of the region to meet public health standards regarding timely notification and follow-up with clients is impacted by client address information. Health cards are used to provide client address information to public health and are not updated frequently. If the address information on a health card is not correct, public health faces challenges in trying to locate clients' correct address information which can impede the ability to provide lab reports to clients in a timely manner.

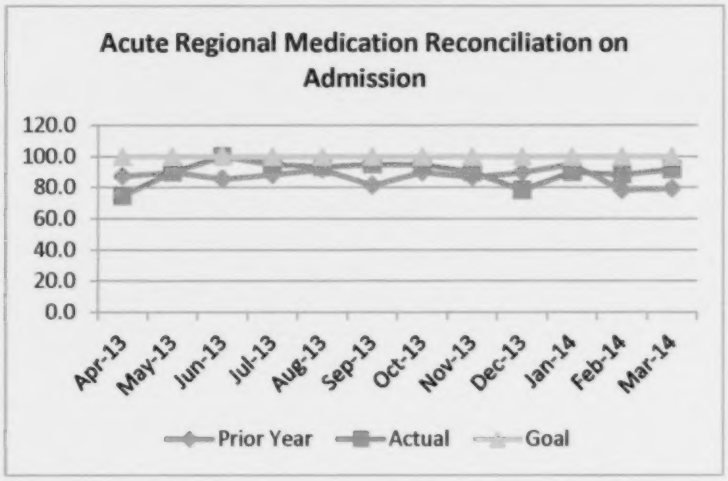
Better Care

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome to establish a culture of safety with a shared ownership for the elimination of defects (uncorrected errors) by 2017.

Improvement Target
By March 2017, there will be zero patients who experience a medication defect.

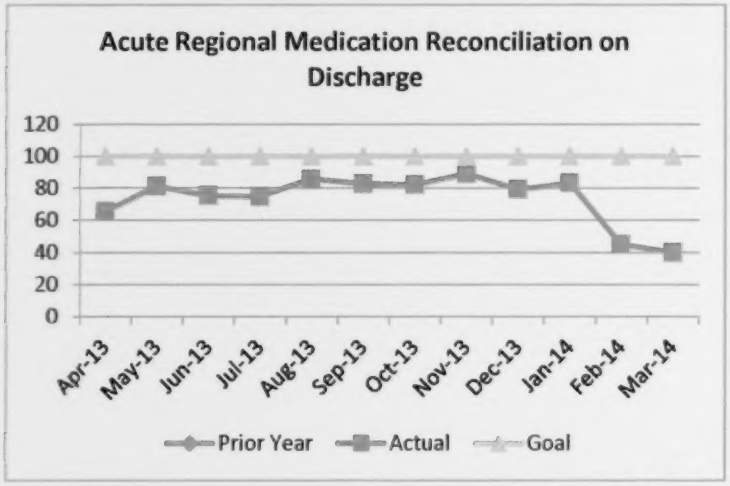
Results:

- The majority of patients, clients and residents receiving health care services in KTHR have chronic diseases managed by multiple medications.
- Medication regimes are often complex and have the potential for adverse drug events/errors resulting in ill health, hospitalization and risk of further injuries such as falls. More than half of medication errors in hospital are related to admission, discharge and transfer. Almost three-quarters of inpatients have at least one medication discrepancy.



Date Prepared: 04/22/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly

- Research indicates medication reconciliation at transition points decreases harm to individuals, shortens length of hospital stay and reduces re-hospitalization.



Date Prepared: 04/22/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly

- Implementation of medication reconciliation on admission and discharge in acute care facilities in KTHR was completed in February 2013. All acute facilities have achieved varying degrees of success with compliance. Currently, compliance with medication reconciliation on discharge is a greater challenge than admission.

- With few exceptions, compliance with medication reconciliation on admission has improved over the previous year, meeting or exceeding the 2012-13 rates most months. The goal of 100% compliance was achieved regionally in the month of June 2013. The average rate of compliance in 2013-14 was 90%, a significant improvement over the previous year's average of 75%.

- Compliance with medication reconciliation on discharge did not meet the goal of 100% in 2013-14 but was relatively stable from May through January. The highest compliance rate achieved during the year was 89% in November 2013. In February and March 2014, compliance dropped significantly and at year-end reached an all-time low of 40%.

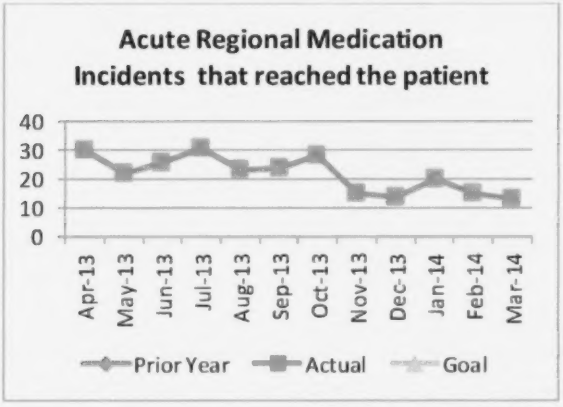
- Many facilities struggle with lack of pharmacy services on weekends and no Targeted Date of Discharge (TDD). Implementation of TDD has been identified for future improvement work.

As a part of Lean Leader Training and participation in the North American Tour in May 2013, five KTHR Lean Leaders participated in a mistake proofing project that focused on eliminating defects in prophylactic antibiotic administration in surgical cases. The report out for the project was held in September and, through Value Stream Mapping, identified the following opportunities for improvement:

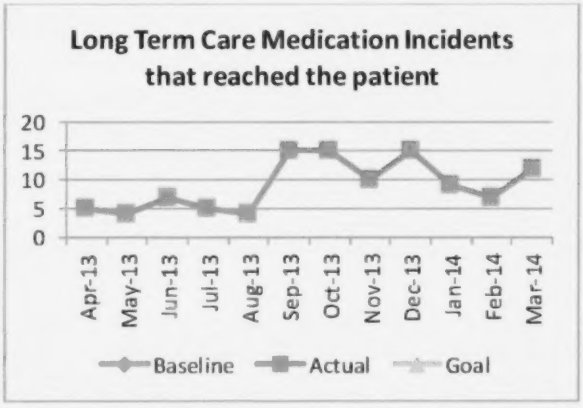
- Surgical checklist not detailed enough
- No standard work for prophylactic medication administration

Defect data collected identified missed dose (4.4%), incorrect dose (15.4% for weight-based) and incorrect time (2.2%) as potential improvement areas. The Surgical Team trialed several Plan Do Study Act (PDSA) cycles and implemented several strategies to improve the mistake proofing level from 3 to 4 and achieve zero defects for missed dose and incorrect time. The team continues to work on standardizing weight-based dosing. Audits completed at 30, 60 and 90 days indicated the team maintained zero defects for missed dose and incorrect time.

- The region has improved the number of acute medication incidents that reached the patient with a steady decline in reported incidents. In long term care, the number of incidents was relatively low early in the fiscal year before increasing significantly from August to October 2013.



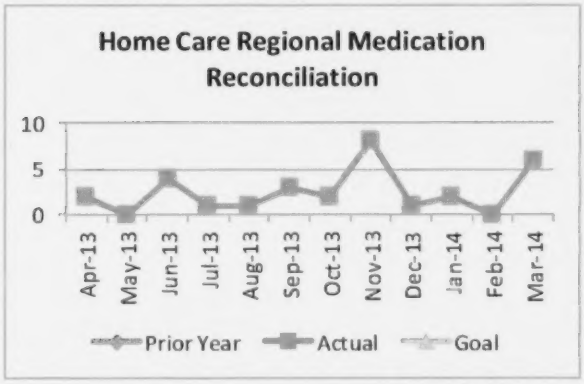
Date Prepared: 04/23/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly



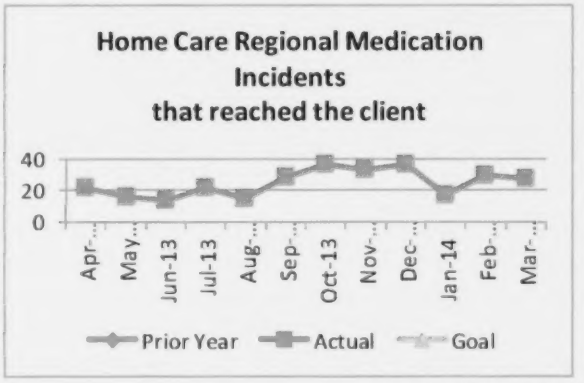
Date Prepared: 04/22/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly

- The increase in long term care medication errors is a concern. Insufficient physician coverage and pharmacy support present barriers to improvement.
- The increase in long term care may also be attributed to data collection that reflects all medication incidents, as opposed to just those that reached the resident.
- Corrective action that has been implemented to date include:
  - follow-up discussions with Facility Administrators to ensure all medication incidents are reported and investigated as close to the time of the incident as possible;
  - weekly review of patient safety issues and incidents, including medication incidents, during acute care conference calls;
  - review of safe medication administration principles at daily huddles and discussion about all medication incidents at vis walls;

- Facility Administrator reinforcement of "no interruptions", with the exception of emergencies, during the medication pass; and
- a regional review of the incident reporting process.



Date Prepared: 04/22/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly



Date Prepared: 04/22/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly

Baseline audit data on home care medication reconciliation was completed in the 2013-14 fiscal year.

- Implementation of medication reconciliation in home care required several PDSAs (Plan Do Study Act) resulting in creation of a standard work document which guides regional home care practices.
- Prescriber response to the implementation of medication reconciliation continues to be positive. Medication reconciliation in home care uncovered the use of many herbal medications which home care providers and the prescriber may not have previously been aware of.
- Home care utilizes the STOPP Beers list of medications to identify potential risks to clients. Medication reconciliation implementation in acute care has contributed to decreased medication discrepancies among home care clients.
- Many of the medication errors reported in home care are due to bubble packaging. Though recorded as an error, identifying bubble packaging errors actually prevents the client from receiving the incorrect medication or dose.
- The focus of medication reconciliation in home care has shifted to best possible medication history on clients being discharged from home care and admitted into long term care.

The overall barriers to medication reconciliation compliance in acute, long term and home care include:

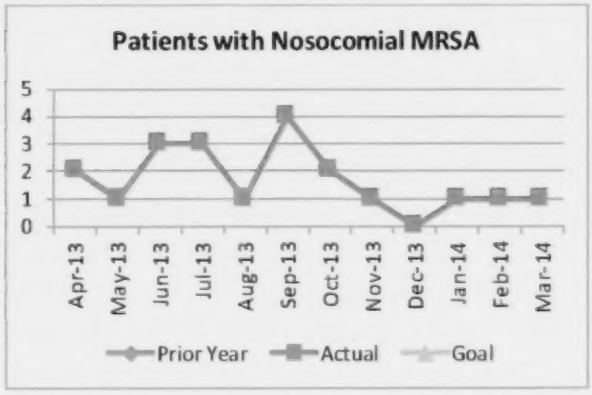
- lack of understanding of the connection between potential patient harm as the result of failure to reconcile medications;

- the amount of time reconciling medication takes;
- blind trust in other systems that results in a failure to reconcile medications;
- technology issues with systems such as PIP, which provide incomplete medication information such as no record of over-the-counter medications; hand written instructions on bottles; and when samples have been provided; and
- duplication of work – medication reconciliation is completed by community pharmacies, acute care, long term care and home care.

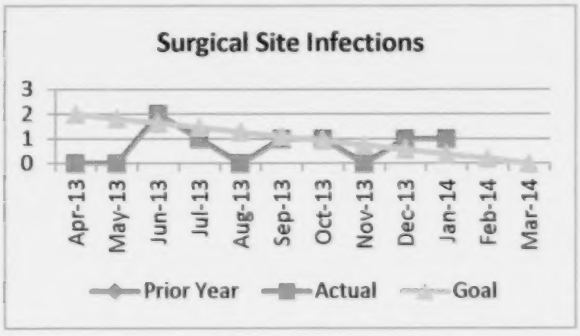
Improvement Target
By March 2017, there will be zero patients who experience a preventable surgical site infection (SSI) from clean surgeries (national Healthcare Safety Network (NSHN) class I, II).

Results:

- Health-care associated infections (HCAI's) are the most common serious complication of hospitalization.
- Nosocomial methicillin-resistant Staphylococcus aureus (MRSA) is a potentially deadly strain of infection that is resistant to several antibiotics and is appearing more frequently in hospitals and other healthcare settings.
- Many hospital patients carry MRSA, but do not exhibit symptoms of the infection. The spread of the bacteria is most often through inadequate hand washing and/or inadequate environmental cleaning following direct or indirect care.
- KTHR data is not presently linked to client/patient/resident status – infections and colonization is tracked. Relationship to mortality is not tracked.

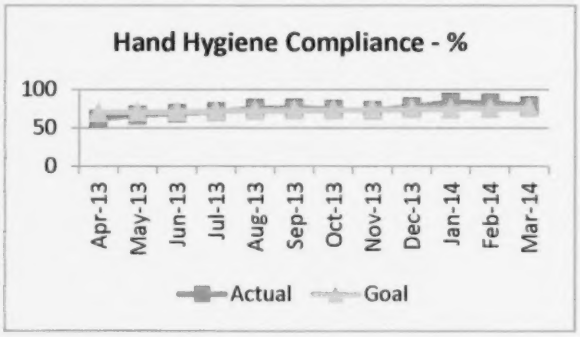


Date Prepared: 04/22/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly



Date Prepared: 03/19/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly

- KTHR has largely remained below the regional median of 1.5, averaging one patient with nosocomial MRSA per month throughout most of 2013-14 with the exception of September when the region saw a spike of four. In total, 21 cases of healthcare acquired MRSA were reported in KTHR in 2013-14.
- Seven post-operative surgical site infections were recorded in 2013-14 therefore KTHR did not meet the 0% target. SSI cases are forwarded on a case-by-case basis to the site specific surgical team for follow-up. KTHR actively participates in the provincial SSI bundle compliance monthly audit.
- Nosocomial MRSA and post-operative surgical site infections are directly related to hand hygiene.



Date Prepared: 03/24/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly

- Staff working in health care settings believe they are practicing good hand hygiene however KTHR hand hygiene compliance rates are less than 100% for routine care/service delivery. An increase in hand hygiene adherence of only 20% results in a 40% reduction in the rate of health care associated infections (HCAIs).
- Monthly hand washing audits began in January 2013. KTHR initially targeted a 70% compliance rate with gradual movement to 75% by March 2013. Regional compliance started below the target but has improved to reach or exceed the target every month since July 2013.

Improvement Target

By March 2017, there will be zero workplace injuries.

Results:

- In 2013-14, KTHR's staff injury rate followed similar trending as the previous fiscal year, remaining above both the 2012-13 rate and the regional target.
- Healthcare has the highest workplace injury rate of any industry in the province.

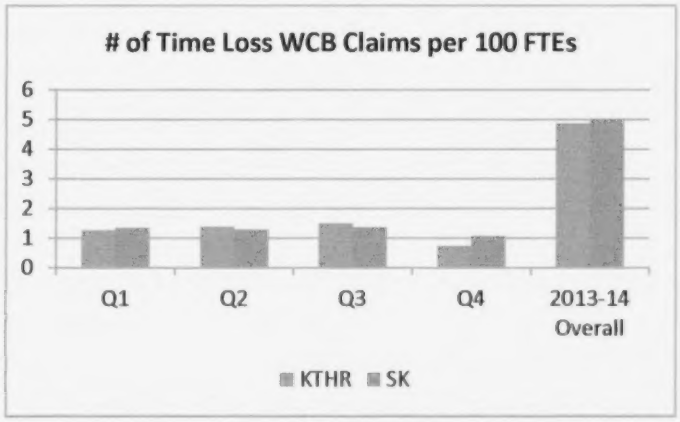
Date Prepared: 04/22/2014
Report Contact: Shane Merriman, VP Corporate Services
Refresh Cycle: Monthly

- Kelsey Trail Health Region's injury rate is lower than the provincial industry code for healthcare organizations this year. Last year it was higher.
- Workplace injuries have a significant impact on employees' quality of life, adversely affecting life inside and outside the workplace, and employees' families. Every employee should be able to come to work and return home safely each day.

Measurement Results:

Number of accepted WCB time loss injury and medical aid claims

- KTHR reported 4.53 time loss Worker's Compensation Board (WCB) claims per 100 FTEs in 2013-14, slightly less than the provincial average of 4.75 and a ten percent decrease from the previous fiscal year.
- KTHR identified safety training for supervisors as an area for focus in the 2013-14 fiscal year.



Source: Revised WCB Accepted Injury Claims 2013-14 Workforce Planning Branch, Ministry of Health

- An initial training blitz saw over 90% of out-of-scope Managers, Directors and Vice-Presidents as well as 180 in-scope supervisors receive Safety for Supervisors training. Moving forward, the regional goal is to ensure 100% of OOS Managers, Directors and VPs attend the training and all new OOS managerial hires attend a training course within three months of their hire date. In and out-of-scope employees who may oversee the work of others are also encouraged to attend the training.
- Safety for Supervisors training helps KTHR fulfill its responsibility as an employer as set out in Regulations 17 & 469.1 of *The Occupational Health and Safety Regulations, 1996* which require employers to ensure that supervisors possess the knowledge and are experienced in matters that are within the area of the supervisor's responsibility.
- In response to the increase in time loss injuries within the region last year, an injury alert process for long term care nursing employees injured on the job was implemented in October 2013. The new process increases the region's ability to be more proactive in managing injuries and preventing them from becoming time loss WCB claims.
- Based on the success of the implementation in long term care, the process was rolled out region-wide in November 2013.

- Through the new process, injured employees are asked to call the Human Resources (HR) injury alert line within 60 minutes of sustaining an injury. HR assesses the severity of the injury along with the probability of it becoming a time loss claim before following up with Department Managers and/or Facility Administrators to assist employees through the next steps. The goal of the process is to contact the injured employee before their next scheduled shift to offer light duty or alternate work where possible, and prevent time lost due to the injury.

In late February 2014, the region invested in additional support for injury prevention through the hiring of a full-time Regional Safety Officer. Working with the Workplace Health and Safety Coordinator, the role of the Regional Safety Officer is to work toward eliminating all workplace injuries and increase workplace safety. The Safety Officer supports managers and Occupational Health & Safety Committee co-chairs in reviewing incidents, identifying and addressing root cause.

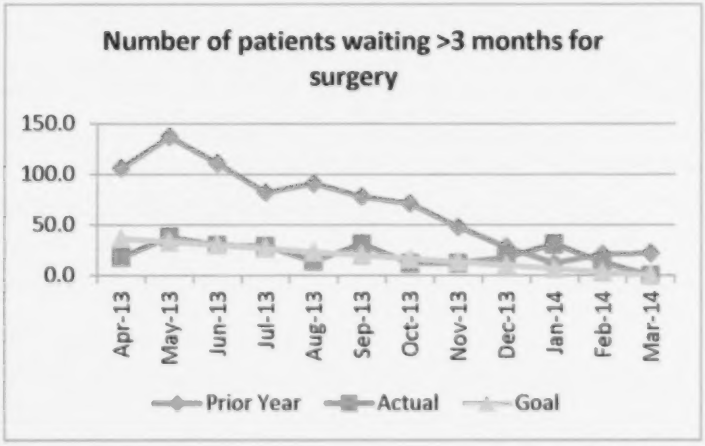
Better Care

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome that by March 2017, all people have access to appropriate, safe and timely surgical and specialty care (cancer, specialist, and diagnostics) as defined by the improvement targets.

Improvement Target
By March 2014, all patients have the option to receive necessary surgery within three months.

Results:

- KTHR achieved the target for all patients to have the option to receive necessary surgery within three months by March 31, 2014.
- At the conclusion of the four year Saskatchewan Surgical Initiative (SSI) on March 31, 2014, KTHR was one of four health regions in



Date Prepared: 04/28/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly

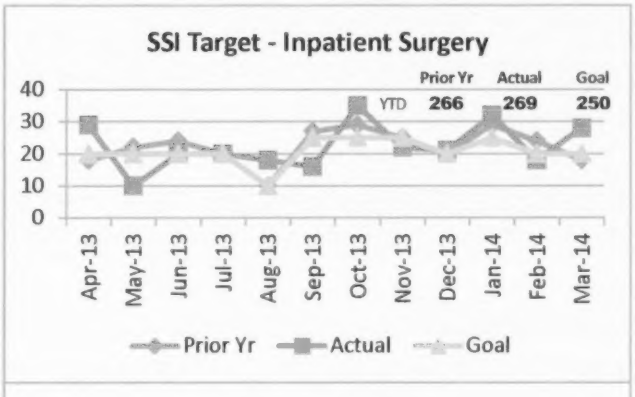
the province to achieve the three month wait time target.

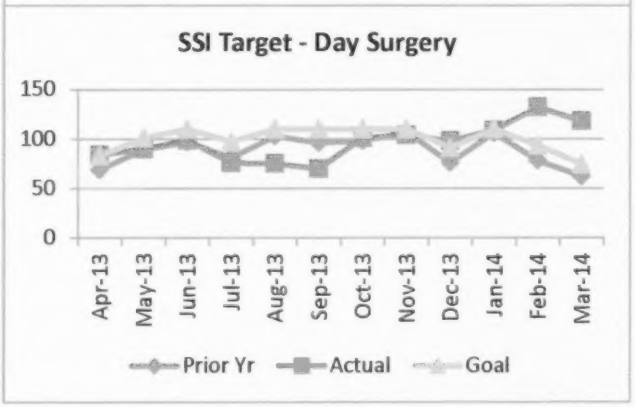
Measurement Results:

Number of patients waiting more than three months for surgery

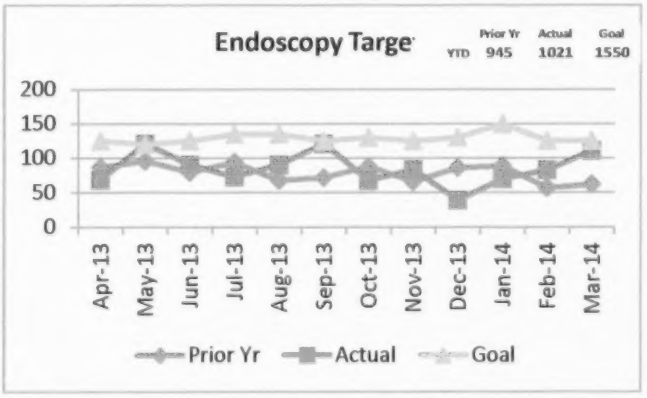
- Since the SSI began in 2010 there has been a 75% provincial reduction in patients waiting more than three months to receive surgery. In KTHR, the reduction has been 100%.
- No surgical wait times have exceeded six months in Kelsey Trail for the past two years. No surgical wait times have exceeded 12 months in the region since 2007.
- In December 2013, the region submitted a plan to reduce the number of patients waiting greater than three months for surgery to zero, which included:
    - extending the cataract surgery day to complete an additional one to two procedures to eliminate the cataract wait list;
    - offering dental cases exceeding the wait the opportunity to have their surgery done by another dentist; and
    - extending dental OR days to accommodate additional clients.
- In some cases patients cancel or do not show up for their surgery. These cases appear on the list as patients waiting greater than three months for their surgery. If these cases are not able to be rescheduled, they can impact the region's ability to achieve the target of zero.
- Compliance with the 3-part Surgical Safety Checklist implemented regionally in 2011-12 remains at 100%. Adverse events are easily prevented with 100% compliance with the Surgical Safety Checklist. Compliance also improves the patient experience, increases satisfaction and public confidence in the healthcare system, and decreases overall cost.
- The Regional OR Manager began work toward the implementation of the Surgical Site Infection Control Bundles prior to their provincial implementation in April 2014. Compliance rates will be audited on caesarean sections and bowel surgery.
- KTHR met the SSI target for inpatient surgeries, exceeding the goal to complete 250 inpatient surgeries with a total of 269.
- The region did not meet the 2013-14 SSI target for day surgery. This has been attributed to the 187 surgical "no shows", cancellations and surgeries on KTHR patients that were performed out of region.
- The region's original target was set at 1,475 day surgeries, a reduction of 125 from the previous year.

- Even with the reduced target, there was concern with the region's ability to meet the new target due to challenges related to lack of flexibility to fill OR slates when there are cancellations or "no shows"; last minute cancellations by itinerant surgeons; or itinerant surgeons booking KTHR patients into their urban home location for their surgeries, rather than KTHR, due to increased access to OR suites in regional or tertiary centres.
- The loss of surgical procedures and inability to meet the surgical target resulted in a substantial decrease in funding for KTHR. The region was short 249 cases from target the previous year which resulted in a $356,500 reduction to the surgical budget. The reduction of 125 procedures in 2013-14 resulted in an additional loss of $186,000 from the surgical budget.
- KTHR was unable to meet the 2013-14 endoscopy target of 1550, falling short 529 procedures.
- KTHR's resident surgeon performs a high number of endoscopic retrograde cholangiopancreatogram (ERCP procedures, including referrals from Prince Albert. This provides less time for endoscopy and surgery. ERCP procedures are not recognized as part of the SSI initiative. KTHR is the only rural health region to offer this service to patients living both within and outside its boundaries.





Date Prepared: 04/22/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly



Date Prepared: 04/22/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly

- The colorectal screening program has increased referrals and demand for endoscopy. In KTHR, surgery and endoscopy require the same staff therefore the surgical and endoscopy targets cannot be completed simultaneously.
- The region continues to work with the resident and itinerant surgeons in an attempt to increase endoscopy volumes and offers extra days for endoscopy, as available.

Improvement Target
By March 31, 2015, all cancer surgeries or treatments are done within the consensus timeframe from the time of suspicion or diagnosis of cancer.

Results:

- Based on data from the May 25, 2014 refresh of the Saskatchewan Surgical Patient Registry data mart, KTHR data on patients waiting for surgery for cancer or suspected cancer for the 2013-14 fiscal year was supressed because less than 20 procedures were performed. In total, KTHR performed seven surgeries for cancer or suspected cancer during the period from October 1, 2013 and March 31, 2014.

Measurement Results:

Number of patients waiting longer than three weeks for treatment after suspicion or diagnosis of cancer

- In KTHR, less than five patients categorized with a surgeon priority of three weeks were waiting for surgery as of March 31, 2014. Provincially, 74% of cases were performed within three weeks with 90% performed within five weeks or 35 days. Due to the low number of procedures in KTHR, the percentage of surgeries performed within the target timeframe was unavailable.

In March 2014, the Saskatchewan Cancer Agency offered KTHR a Patient Navigator for the Colorectal Cancer Screening program. The Patient Navigator will assist General Practitioners with some of the workload created when a patient has a positive Fecal Immunochemical Test (FIT) test, a colorectal cancer screening tool. The Patient Navigator is expected to begin working with patients early in the new fiscal year.

The Saskatchewan Cancer Agency plans to implement the electronic health record to all Community Oncology Program of Saskatchewan (COPS) sites in the province in the new fiscal year. KTHR offers the COPS program in Melfort, Nipawin and Tisdale. Patient care will benefit from the implementation of the electronic health record.

Better Care

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome that by March 31, 2017, no patient will wait for care in the Emergency Department (ED).

Improvement Target
By March 31, 2015, decrease by 50% the wait times in the ED.

Results:

KTHR Hoshin/Project #2: Appropriate access to care for Canadian Triage & Acuity Scale (CTAS) 4 & 5 patients in Melfort

- Melfort Hospital does not have a dedicated ER physician. ER call is one of multiple demands on physicians, which also includes anaesthesia, surgery, obstetrics, and satellite clinics out of town.
- ER clients and those scheduled for outpatient procedures wait in the same line for registration, regardless of their medical condition.
- The majority of patients visiting the Melfort ER are CTAS 4 and 5. These patients are not aware of the process to access a physician if their family physician is not available or if they do not have a family physician.
- Following triage, CTAS 4 & 5 clients with a family physician are redirected back to the physician clinic to receive service. Those without a family physician are also redirected back to the clinic to try to schedule an appointment.
- Patients triaged as CTAS 3 may also be redirected back to the physician clinic which is sometimes not the appropriate place for them to be seen. Redirecting patients from the ER to the physician clinic, which is not located in the hospital, is not a patient-centred practice.
- There is no standard method all physicians use to see clients that present at the ER as CTAS 4 or 5.

In October, 2013, the KTHR Kaizen Promotion Office (KPO), with the support of Health Quality Council (HQC), utilized Value Stream Mapping (VSM) to assess the current state of the CTAS 4 & 5 patients accessing the Melfort ER and develop a future state. Kaizen bursts were identified and an improvement plan was developed and implemented.

5S was completed in ER rooms and was maintained at the 90 day audit. Previously, supplies were not being regularly restocked and providers often had to leave the ER treatment rooms to retrieve appropriate supplies. Triage space was relocated within the ER which has improved both patient confidentiality and traffic flow. The change has been met with positive feedback from nursing staff and patients.

A single access phone number was implemented and trialed for ER staff to access the physician on-call for CTAS 4 & 5 patients without a family physician or whose family physician is away. In February, a clinic space was created in the hospital for the physician on-call to see CTAS 4 & 5 patients away from the ER. Patients call the on-call number for non-urgent situations and can now be seen in the clinic at the hospital instead of being redirected back to the physician clinic off-site. The in-hospital clinic has improved flow in the ER and is considered very positive by the public.

Improvement work accomplished through the Melfort ER Hoshin will continue as daily work in 2014-15 and additional improvement opportunities will be pursued in the new fiscal year.

Better Value	**The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome that by March 31, 2017, as part of a multi-year budget strategy, the health system will bend the cost curve by lowering status quo growth by 1.5%.**

Improvement Target
By March 2015, shared services will improve quality while achieving $100 million in accumulated savings.

Results:

In collaboration with the health regions, 3sHealth celebrated the following key achievements in 2013-14:

- Establishing a linen services agreement that will create a long-term, sustainable solution for healthcare linen services throughout the province, improving the patient experience, ensuring patient and worker safety, and capturing $98 million in savings over 10 years.
- Leveraging of group purchasing contracts to increase the health system's buying power through provincial and national procurement contracts for clinical supplies and services, resulting in new available savings of $7.8 million.

- Completing the Gateway Online project which provides all employees in the Saskatchewan health sector with access to personal employment information in a centralized digital space.
- Exceeding the $10 million annual provincial savings target, producing cost savings for the provincial healthcare system totaling over $23 million.

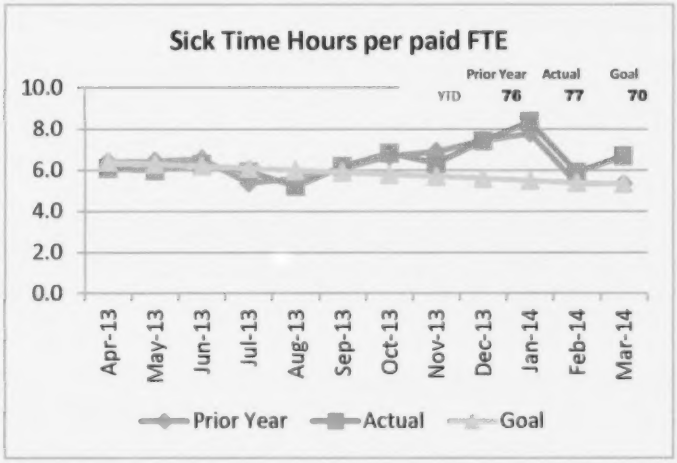
The focus of 3sHealth's work in 2013-14 was on identifying opportunities for improvement that will improve quality of care for Saskatchewan patients and lower the cost curve for the system. As part of this work, 3sHealth explored potential shared services in key areas including medical imaging, medical laboratory services, information services/information management, transcription services, enterprise risk management, supply chain and environmental services.

Through ongoing collaboration with our health region and SCA partners, 3sHealth has exceeded $93 million in total savings, and we are ahead of schedule in our goal of achieving our $100 million five-year target.

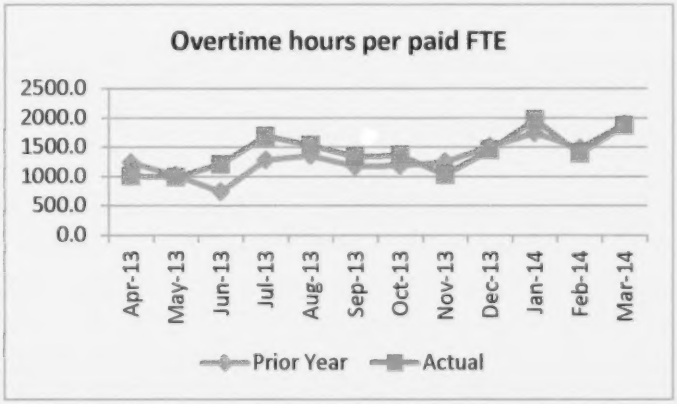
Measurement Results:

Accumulated savings over time

- KTHR achieved $322,000 in year-to-date savings through 3sHealth supply rebates and procurement during 2013-14.
- Through Gateway Online, KTHR completed implementation of my JobPostings and applicant tracking in October 2013.
- Sick time hours continue to be a concern for KTHR. The region's sick time hours per paid full-time equivalent (FTE) were higher than the target in 2013-14 though comparative results indicate a trend similar to the previous year.
- KTHR recorded 77.17 sick time hours per FTE in 2013-14 to exceed the target of 70.



Date Prepared: 04/17/2014
Report Contact: Shane Merriman, VP Corporate Services
Refresh Cycle: Monthly



Date Prepared: 04/17/2014
Report Contact: Shane Merriman, VP Corporate Services
Refresh Cycle: Monthly

The region saw a two percent increase in sick time hours from the previous year's total (75.46 hours per FTE). Provincially, KTHR remained below the provincial average of 78.90 hours per FTE and has the fifth lowest sick time hours among the 12 health regions.

- Sick time hours have been partially attributed to a higher number of maternity leaves compared to previous years and the resulting increase in pregnancy-related illness. In addition, there was an increase in the number of outbreaks in KTHR facilities as compared to previous years. KTHR's aging workforce and a suspected decline in physical fitness and endurance levels is also a contributing factor.
- At 24.49 per FTE, KTHR's wage-driven premium (WDP) hours remain significantly lower than the provincial rate of 40.40 and are the second lowest in the province. However, total regional overtime increased 6.1% compared to last year, moving from 15,855 to 16,827 hours per paid FTE in 2013-14.
- Overtime hours tend to increase during periods of peak utilization and often correlate with sick time. Overtime hours may also be associated with staffing shortages in hard-to-recruit areas.
- Facility-level action plans are being used to address WDP hours, including root cause analysis and changing culture. Focused attention on sick time and overtime at vis walls in facilities and departments has increased awareness of the attention required to manage and decrease these areas. The continued efforts of the Regional Attendance and Disability Support Coordinator are directed at high sick time users.

Better Value	**The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome that by March 31, 2017, all IT equipment and infrastructure will be coordinated through provincial planning processes to ensure provincial strategic priorities are met.**

Improvement Target
By March 31, 2014, eHealth and 3sHealth will work in partnership with key stakeholders to develop a strategy to integrate Information Technology (IT)/Information Management (IM) services throughout the health system.

Results:

- KTHR received $116,000 in funding for two projects through the eHealth Transformation Fund, a one-time fund for small information management services and technology

projects critical to the success of the health sector and in support of eHealth Saskatchewan's mandate.

- KTHR's approved projects included:
    - Uniprint: a print management solution to improve print functionality, provide secure print services and increase efficiencies in operations. This initiative aligned with the 3sHealth and eHealth provincial initiatives. Unfortunately, the software solution provided did not fulfill the needs of the scope of the project and it was cancelled.
    - Technology for Home Care Direct Service Providers: improving technology to increase the efficiency of home care field staff by allowing for real time updates of client information. This project is still in the process of being completed.

Measurement Results:

Number of hospitals by region having all three ancillary IT systems (lab, radiology and pharmacy) installed, if required

The Pharmacy Information Program (PIP) is currently installed in the three district hospitals in KTHR. The three community hospitals in the region do not have pharmacists on staff and therefore, do not currently require the system.

KTHR was the first health region in the province to connect all six acute care sites with a regional Picture Archiving & Communication System (PACS) in 2010 and in June 2012, the KTHR PACS moved to the provincial PACS as part of the second phase of the provincial RIS (Radiology Information System)-PACS. RIS-PACS may be accessed at all of the physician clinics in the region, all Therapies locations and at community chiropractic offices. The Lab Information System (LIS) was implemented at all six KTHR acute care sites in May 2011 and, as a result, KTHR became the first health region in the province to contribute patient lab results information from all acute sites in the region to the Saskatchewan Lab Results Repository when it was introduced in April 2012. In addition to the region's acute care sites, the LIS is also installed at the Carrot River Health Centre.

The RIS-PACS, provincial lab repository and PIP are all part of the existing components of the provincial electronic health record. In March 2014, KTHR became the first health region in the province to provide access to the Electronic Medical Records (EMR) to all physicians. In addition to all physicians, Nurse Practitioners, Diabetes Heart Health Team members, PHC mental health counselors, pharmacists and staff at sites in Nipawin (2), Smeaton, Cumberland

House, Shoal Lake, Red Earth, Tisdale, Porcupine Plain, Kelvington, Arborfield, Carrot River, Melfort and the Therapies department at Nipawin Hospital are also on the EMR.

Through the EMR, community-based physicians and other Primary Health Care providers are able to store, retrieve and work with patient information electronically to facilitate planning and management of individual patient care. Through real-time access to individual patient records, communication between health care providers increases which leads to improved care management and coordination, particularly for patients with chronic conditions and those without a family physician.

EMR implementation began in November 2012 with physician clinics in Melfort. The Tisdale Therapies department will be added in the summer of 2014. Implementation was made possible through the coordinated efforts of KTHR's PHC and IT departments with support of the KTHR physicians and the Ministry of Health. The region provides ongoing network and hardware to support all sites on the EMR.

Better Teams

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome to by March 31, 2017, increase staff and physician engagement provincial average scores to 80%.

Improvement Target
By March 31, 2017, more than 1,000 focused Lean training and kaizen events involving staff, physicians and patients will be undertaken in multiple areas of the health system.

Results:

- KTHR continues to pursue Lean quality improvement initiatives throughout the region.
- In March 2014 KTHR senior leadership and senior leaders from several other rural health regions in the province participated in kaizen planning led by a consultant from John Black & Associates (JBA) and supported by Health Quality Council (HQC). John Black was also in attendance. This planning process helped establish and schedule lean quality improvement priority work for 2014-15.
- In preparation for kaizen planning, Value Stream Mapping (VSM) was completed in all six ERs in the region. High level VSM work was completed by Long Term Care. Training opportunities for 5S, VSM and Kanban were identified through kaizen planning. The region is hosting the representatives of several other RHAs for a week-long Kanban seminar in the new fiscal year.

Measurement Results:

Number of events held

Percent of staff and physicians in Lean training including Lean Leader Certification or Kaizen Basics

Percent of staff and physicians in kaizen events

In addition to the quality improvement work associated with the Kelvington Integrated Facility 3P, 5S improvement work has been undertaken in most facilities or departments throughout the region. During the 2013-14 fiscal year, KTHR staff have been involved in 29 5S campaigns, two RPIWs, three mistake proofing projects and Value Stream Mapping in six ERs, one long term care facility, and four PHC medical clinics.

Challenges related to with advancing regional lean quality improvement work include:

- conflicting priorities for resources within the region;
- limited management capacity and knowledge of lean;
- the existing healthcare culture does not yet support the lean management system; and
- limited capacity for KPO staff to support lean quality improvement work region-wide.

As of March 31, 2014, the region had a total of 14 physicians, senior leaders, KPO staff and Board members at various phases of participation in Lean Leader Certification training. This represents less than one percent of the region's total staff. Three more senior leaders and one physician will begin Lean Leader Certification training in June 2014. The 2013-14 target for Kaizen Basics training was exceeded with a total of 578, or 35% of staff trained as of March 31, 2014, well ahead of the goal of 400.

Improvement Target
By March 31, 2017, 100% of staff and physicians are continuously improving care and service through visual daily management.

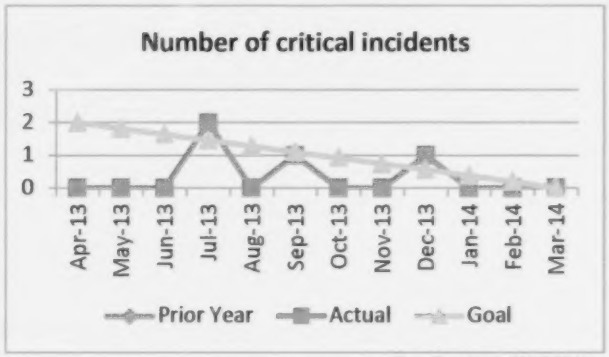
Results:

Visual daily management was implemented at all KTHR facilities in 2012-13 by Facility Administrators with the support of the KPO. Several departments also implemented vis walls and continue to fine tune their metrics with the support of the KPO. Work on the continued implementation of daily visual management and aligning vis wall metrics with the regional vis wall is an ongoing process.

KTHR Patient First Progress

KTHR monitors a number of Quality, Cost, Delivery, Safety and Morale (QCDSM) metrics that are not considered strategic priorities in the 2013-14 fiscal year but are aligned to provincial outcome targets. These metrics also provide continued focus and support for quality improvement initiatives that benefit patients, clients, residents and their families.

Critical Incidents



Date Prepared: 04/15/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly

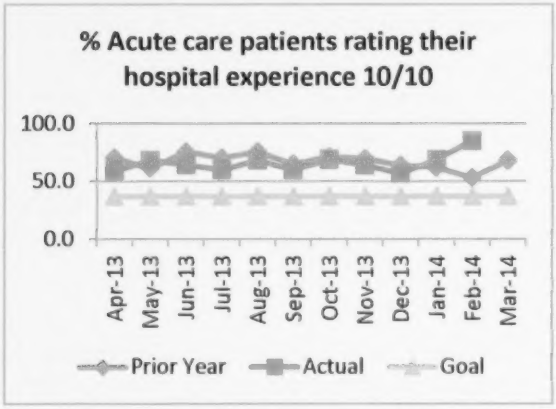
Critical incidents are defined as "a serious adverse health event including, but not limited to, the actual or potential loss of life, limb or function related to a health service provided by, or a program operated by, a regional health authority (RHA) or health care organization (HCO)." The KTHR Quality of Care Coordinator is responsible for identifying events where a patient is harmed (or where there is a potential for harm), reviewing and conducting an investigation into the incident and implementing necessary changes within the region that are reviewed and may be implemented provincially.

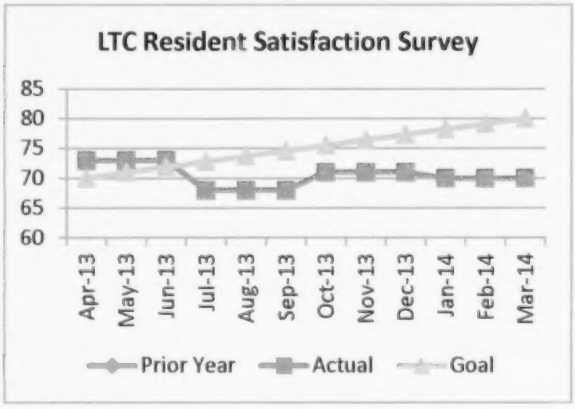
While relatively low, KTHR reported a total of four critical incidents in 2013-14 which is a concern given the ultimate goal to have no incidents that do or have the potential to harm patients. Of the four critical incidents reported during the fiscal year, none have any outstanding system or departmental recommendations that have not been implemented.

Client Experience Surveys

Using baseline data from the HQC Patient Experience Survey indicator, Kelsey Trail has consistently met or exceeded the provincial target of 37.1% in the 2013-14 fiscal year, which is consistent with the region's performance over the previous two years. HQC discontinued reporting on this quality indicator in March, 2014 in response to feedback regarding other

potential approaches to patient surveying that better meet RHA needs. An advisory group has been formed to explore options for obtaining feedback from patients about their acute care experiences.





Source: Health Quality Council Quality Insight

Date Prepared: 03/20/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly

Through the KTHR implementation plan for Patient and Family-Centred Care, client experience surveys have been initiated in other service, including long term care. Long term care surveys are distributed on a quarterly basis and measure if staff *listened and respected (long term residents) as a partner in their care*. After exceeding the target for several months, survey results have consistently remained below the target through the rest of the fiscal year.

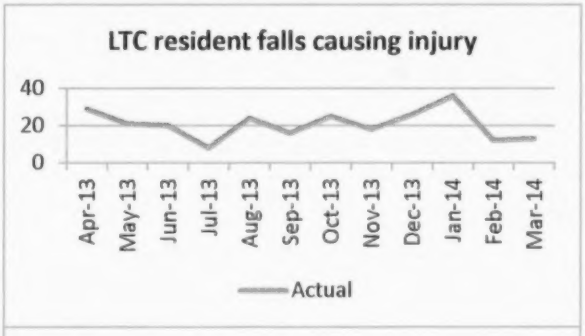
Falls

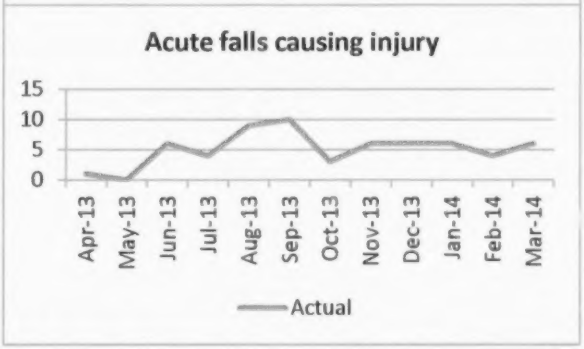
The KTHR long term care falls reduction program was a feature presentation at the Health Quality Summit in April 2013. Key to the success of the regional fall program is the individualized approach to care planning and addressing fall reduction on a resident-by-resident basis. The cumulative efforts of providing customized solutions that fit the needs of each high risk resident have resulted in the overall rate of reduction in falls achieved at the facility level and regionally.

Falls and injuries associated with falls take a physical and emotional toll on patients, clients and long term care residents. By focusing on prevention, the quality of life for patients and residents can be improved and, as a result, the cost to the health care system can be reduced.

Fall reduction and is an ongoing priority for the region. Falls reduction work has become part of daily management for most long term care facilities and is a prominent feature on visibility walls across the region.

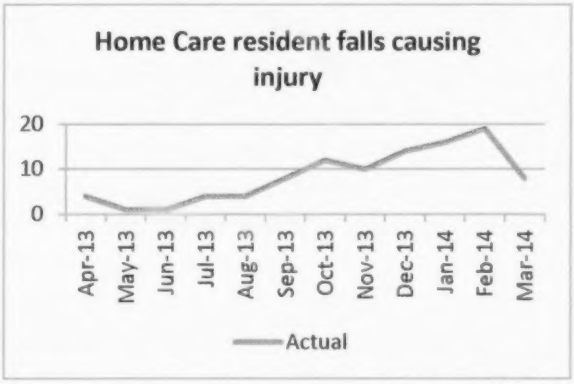
A spike in long term care falls in January 2013 was attributed to a significant increase in falls in one facility in the region. Focused facility-level improvement work, which included increasing staff awareness through increased surveillance and intentional rounding, and staff suggestions for resident safety within the facility, has resulted in a decrease in resident falls. Facility-based Daily Management Boards (DMB) and visibility walls provide information on residents who are at extremely high risk of falling and track the number of falls. In addition, residents and families are encouraged to "call, not fall". One of the challenges associated with falls reduction is the transitional nature of strength, mobility and cognitive changes among long term care residents.





Date Prepared: 04/22/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly

The region is in the process of standardizing the existing long term care falls policy throughout acute care. Acute care patients at higher risk are identified during daily huddles and monitored to prevent falls. Hospital patients are often at higher risk of falls as the result of the severity of the condition or illness that resulted in their admission to acute care.



Date Prepared: 04/22/2014
Report Contact: Pamela McKay, VP Institutional & Emergency Care
Refresh Cycle: Monthly

Home care has historically tracked falls through incident reporting. Through the introduction of daily management and daily morning huddles, the process changed to include tracking and reporting falls which occurred "since yesterday" in order to facilitate real-time discussions about contributing factors and possible care planning interventions to prevent future falls.

In the fall of 2013 tracking expanded to include falls reported by home care clients where there was evidence of injury, which is what the increase in home care falls is attributed to. This step was taken to become more proactive, identify causative/relating factors, initiate early

intervention before there more critical injury resulted, and align with provincial guidelines for reporting.

Home care has reviewed the falls prevention program, created new educational material for staff, adopted the falling star symbol used in the long term care program to identify those at high risk, defined what is high risk, and created a reference document to help guide decision-making. The nursing assessment tool has been modified to incorporate the RAI-HC (Resident Assessment Instrument-Home Care), an internationally validated assessment tool adopted by the province for performing comprehensive client assessments, which helps determine which clients are at high risk. Home care also ensures the regional falls prevention brochure is included with the in-home chart for the education of each client.

Maternal Mental Health Pilot Project

In October 2013, Saskatchewan HealthLine was awarded the RelayHealth 2013 ICARE Bronze Award for a Maternal Mental Health pilot project that involved collaboration with the Ministry of Health Population Health Branch, RelayHealth, Kelsey Trail and Cypress Health Regions.

Kelsey Trail Health Region Public Health and Mental Health employees were involved in the project which focused on providing support to women at risk for postpartum depression and anxiety. The pilot was developed and implemented on August 13, 2013.

HealthLine utilized the RelayHealth Readmission Management module to develop its first outbound call model. The ICARE Award was awarded on the basis of a set of principles used to encourage and evaluate business as well as individuals' conduct within RelayHealth. The principles include: Integrity, Customer-First, Accountability, Respect and Excellence.

Three-Year Clinical Pilot and Feasibility Study

In partnership with a research team from the University of Saskatchewan, KTHR will be involved in a three-year pilot and feasibility study to evaluate and compare three different models of care for chronic low back disorders in a rural Saskatchewan community with limited Physical Therapy services. The pilot is funded through Saskatchewan Health Research Foundation (SHRF) Establishment Grant and additional funding from the Ralston Brothers Medical Research Fund Competition. The research is taking place in Arborfield and Carrot River and involves a partnership of local health care providers, managers, senior leaders and professional association representatives. Funding provided through the Ralston Brothers Medical Research

Fund Competition will result in the purchase of a Telehealth-compatible videoconferencing unit to be installed in the Arborfield & District Health Care Centre. The research team is hopeful the results of the pilot will lead to the development of evidence-informed approaches to improve access to physiotherapy services in rural and remote settings, potentially serve as a model for enhancing other chronic health conditions, and help inform the provincial Primary Health Care remodelling process. The study started in December 2013 and will run until the fall of 2016.

Management Report

May 28, 2014

KELSEY TRAIL HEALTH REGION
REPORT OF MANAGEMENT

The accompanying financial statements are the responsibility of management and are approved by the Kelsey Trail Regional Health Authority. The financial statements have been prepared in accordance with Canadian Public Sector Accounting Standards and the Financial Reporting Guide issued by Saskatchewan Health, and of necessity includes amounts based on estimates and judgements. The financial information presented in the annual report is consistent with the financial statements.

Management maintains appropriate systems of internal control, including policies and procedures, which provide reasonable assurance that the Region's assets are safeguarded and the financial records are relevant and reliable.

The Authority delegates the responsibility of reviewing the financial statements and overseeing Management's performance in financial reporting to the Audit & Finance Committee. The Audit & Finance Committee meets with the Authority, Management and the external auditors to discuss and review financial matters and recommends the financial statements to the Authority for approval. The Authority approves the annual report and, with the recommendation of the Audit & Finance Committee, approves the financial statements.

The appointed auditor conducts an independent audit of the financial statements and has full and open access to the Audit & Finance Committee. The auditor's report expresses an opinion on the fairness of the financial statements prepared by Management.

Shane Merriman, CMA
Chief Executive Officer

Connie Glaves
Director Finance

2013-14 Financial Overview

Kelsey Trail Health Region recorded an operational surplus, before interfund transfers, of $786,276. The region is required to make transfers from the operating fund to the capital fund for mortgage payments, the principal portion of the loan on the region's Energy Performance loan, and necessary allocations to Maintenance & Replacement Reserves. Annualized transfers from operating to capital for the 2013-14 fiscal year amounted to $754,777 leaving an adjusted surplus after interfund transfers of $31,499.

The region achieved a balanced budget as the result of a WCB audit that resulted in a refund of $200,000 in premiums; $100,000 in supply rebates from 3sHealth; and lower patient days which resulted in reduced supply costs in drugs, lab, medical/surgical supplies and food totalling $240,000. However, these savings were offset by sick and overtime costs.

The 2013-14 budget was based on budgeted revenues of $121,573,567, an increase of two percent over the previous year. Budgeted expenditures of $120,852,874 increased by 2.08% over the same period, not including appropriations from the operating to the capital fund of .64% required for mortgage payments, the Energy Performance Contract Loan and SHC Reserves. The majority of budgeted revenues are related to increases in compensation-related expenses for health care providers. Salaries, benefits and medical remuneration account for 82% of KTHR's budget.

The 2013-14 budget addressed the Ministry's cumulative efficiency targets to date of $4.1 million, which included targeted savings through efficiencies in attendance support, shared services and general efficiencies required since the 2010-11 fiscal year. The region was expected to achieve an additional $1,600,000 in general efficiency targets in 2013-14. Though not required to meet any efficiency targets for shared services or attendance support in 2013-14, work in this area continued in an attempt to address sick, overtime and WCB costs. Implementation of the regional injury alert line and the hiring of a dedicated Regional Safety Officer are expected to have a positive long-term impact on attendance management. The region also undertook an initiative to review and establish baseline staffing standards through the application of Lean methodology. This work will be extremely important to managing actual costs. Regional budgeting efficiency planning initiatives also include setting stretch targets through the creation of a three year budget plan and monthly reports to help monitor budget variances and communicate changes.

Several factors contributed to achieving the region's $1.6 million efficiency target including a WCB rate reduction, a Collective Bargaining Agreement (CBA) change related to SUN retention, administrative efficiencies, vacancy management, supply or non-salary savings, minor service

changes and one less statutory holiday in the 2013-14 fiscal year. An improved hiring process and vacancy management continue to play an important role in achieving efficiencies. Several quality improvement initiatives were undertaken through Lean in an effort to eliminate waste and create value for patients and clients. The region's financial viability continues to take priority and the region continues to make every effort to ensure change is managed with a focus on minimizing impact on patients while achieving efficiencies and best practice.

The region's operating pressures are influenced by several factors, particularly the growing costs associated with supporting current health services including:

- advances in technologies, procedures and drugs;
- increased emphasis on environmental/infection control, quality improvement and patient safety;
- human resources shortages, including physicians;
- recruitment costs and incentives required to remain competitive in the marketplace; and
- education and training of staff, both mandatory and other.

Regionally, services and processes continue to be reviewed in an effort to adopt best practice and achieve further efficiency, including the implementation of Lean quality improvement initiatives. Strategies continue to be developed to achieve a balanced financial position in 2014-15 in an effort to achieve long term sustainability and fiscal efficiency.

Capital equipment requests continue to surpass the capital funding available to the region. Advances in technologies, aging equipment and facilities impact the ability to meet the capital needs of the region. The 2013-14 capital budget of $1.9 million targeted new technology and equipment to address quality and patient safety. Priority items on the capital budget included additional medical and surgical equipment, patient care and safety, lab and diagnostic imaging equipment, technology and the ongoing work associated with the planning and construction of capital projects in Kelvington and Tisdale. In 2013-14, the capital equipment funding allocation was $55,000 for general capital equipment. Items that were not considered priority for the 2013-14 capital budget were added to the region's five-year capital equipment plan.

In May 2013, KTHR received $634,260 in funding through the Saskatchewan Surgical Initiative (SSI). The funding enabled the region to provide home care to support surgical patients, for post-operative rehabilitation for surgical patients and to cover hospital and capital equipment costs. Funding through KTHR and the SSI resulted in the purchase of a new digital dental x-ray unit for the Nipawin Hospital surgical suite in March 2014. Nipawin Hospital is the site of all dental surgeries in the region. The new equipment improves treatment for young surgical dental patients.

In December 2013, KTHR received one-time funding of $550,000 through the provincial Urgent Issues Action Fund to address priority issues identified through the CEO's tour of KTHR long term care facilities earlier in the year. The funding was used to purchase priority equipment for lifting, moving and bathing residents and invested into nurse call systems to support timely response to prevent falls. The funding also supports the addition of increased staffing to support recreational programming in all long term care facilities and the addition of weekend recreational programming. In addition, staff are receiving training in the Gentle Persuasion Approach, which helps employees understand how to properly care for residents with dementia. KTHR will receive annualized funding of $250,000 from the Ministry of Health to support these initiatives.

The long term care replacement project in Tisdale proceeded on schedule in 2013-14 with the second phase, the construction of the new three cottages, completed in January 2013. The residents of Newmarket Manor officially took occupancy of the new building on March 17, 2013 and renovations to their former residence began soon after. The renovations, which will include the addition of one common kitchen, dining and living area as well as aesthetic upgrades to the interior and exterior of the building, are expected to be completed in late fall 2014. Sasko Park Lodge residents will move into the renovated portion of the building at which time Sasko Park Lodge will be decommissioned. The new facility will be known as Newmarket Place.

The region struggles to generate donations for the equipment and furnishings for Newmarket Place. In 2012-13 the Newmarket Place furnishings and equipment fund benefited from a bequest in the amount of $410,448.24 and an additional donation of $140,000 from the Tisdale Trust Committee resulted in a grand total of $550,000 in funding for the equipment and furnishing of Newmarket Place. The region remains approximately $120,000 short of reaching the $750,000 fundraising goal.

The Kelvington long term care project continued to advance throughout 2013-14. Through the application of Lean methodology, further efficiencies in patient and provider flow were achieved and reinvested into the renovation budget for Kelvindell Lodge. The application of Lean methodology such as 5S continued at both Kelvington Hospital and Kelvindell Lodge and the efficiencies achieved will be applied to processes and operation of the new facility. The region expects to confirm a commitment from the municipal stakeholders for their 20% share ($3 million) of the total capital costs of the project early in the new fiscal year. The Ministry of Health will fund the remaining 80%. The project designs have progressed to the 66% stage and are expected to reach 99% completion early in 2014-15 at which point they will be submitted to the Ministry of Health for final approval. The health region is optimistic construction will start in the summer of 2014. Fundraising for the equipment and furnishings

for the new facility has been undertaken by the Kelvington & District Health Care Facility Foundation.

KTHR has been working to complete its highest priority life safety/emergency and infrastructure needs with $4.1 million in infrastructure funding received through the provincial government's $1.5 billion *Ready for Growth* infrastructure initiative initially announced in 2008-09. The region has upgraded, replaced or installed nurse call systems, security systems, and fire alarms at a number of facilities. In addition to the safety equipment improvements, the region also completed work on emergency generators, heating and cooling systems, humidity control system, and building repairs and maintenance.

Community trusts, foundations and auxiliaries also provide invaluable support to the region in providing financial resources to help meet capital equipment needs.

NeuPath Group, PC Inc.
Chartered Accountants

INDEPENDENT AUDITORS' REPORT

To the Board of Directors
Kelsey Trail Regional Health Authority

We have audited the accompanying financial statements of Kelsey Trail Regional Health Authority, which comprise the statement of financial position as at March 31, 2014, the statements of operations, changes in fund balances and cash flow for the year ended March 31, 2014, and notes, comprising a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform an audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design auditor procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Kelsey Trail Regional Health Authority as at March 31, 2014, its results of operations, its changes in fund balances and its cash flows for the year ended March 31, 2014, in accordance with Canadian public sector accounting standards for government not-for-profit organizations.

Chartered Accountants

Nipawin, Saskatchewan
May 28, 2014

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
STATEMENT OF FINANCIAL POSITION
As at March 31, 2014

Statement 1

	Operating Fund	Restricted Funds: Capital Fund	Restricted Funds: Community Trust Fund	Total 2014	Total 2013
ASSETS					
Current assets					
Cash and short-term investments (Schedule 2)	$ 9,958,300	$ 5,297,957	$ 3,519,569	$ 18,775,826	$ 17,343,464
Accounts receivable					
Ministry of Health - General Revenue Fund	91,922	563,521	-	655,443	2,625,860
Other	1,243,195	84,119	-	1,327,314	1,512,117
Inventory	584,485	-	-	584,485	574,194
Prepaid expenses	870,667	-	-	870,667	926,203
	12,748,569	5,945,597	3,519,569	22,213,735	22,981,838
Investments (Note 2, Schedule 2)	1,222,537	-	-	1,222,537	1,221,325
Other assets	32,113	-	-	32,113	31,089
Capital assets (Note 3)	-	57,670,888	-	57,670,888	51,401,546
Total Assets	$ 14,003,219	$ 63,616,485	$ 3,519,569	$ 81,139,272	$ 75,635,798
LIABILITIES & FUND BALANCES					
Current liabilities					
Accounts payable	$ 2,756,002	$ 1,553,718	$ -	$ 4,309,720	$ 3,640,733
Accrued salaries	4,487,306	-	-	4,487,306	1,768,165
Vacation payable	7,205,492	-	-	7,205,492	6,958,007
Long term debt - current (Note 5)	-	673,801	-	673,801	643,113
Deferred revenue (Note 6)	1,087,541	-	-	1,087,541	2,052,617
	15,536,341	2,227,520	-	17,763,860	15,062,635
Long term liabilities					
Long term debt (Note 5)	-	8,752,239	-	8,752,239	9,446,340
Employee Future Benefits (Note 10)	4,113,400	-	-	4,113,400	4,149,100
Total Liabilities	19,649,741	10,979,759	-	30,629,500	28,658,075
Fund Balances:					
Invested in capital assets	-	48,244,847	-	48,244,847	41,312,094
Externally restricted (Schedule 3)	-	2,370,729	3,519,569	5,890,298	9,251,122
Internally restricted (Schedule 4)	-	2,021,149	-	2,021,149	2,092,529
Unrestricted	(5,646,522)	-	-	(5,646,522)	(5,678,021)
Fund balances – (Statement 2)	(5,646,522)	52,636,725	3,519,569	50,509,773	46,977,723
Total Liabilities & Fund Balances	$ 14,003,219	$ 63,616,485	$ 3,519,569	$ 81,139,272	$ 75,635,798

Commitments (Note 4)
Pension Plan (Note 10)

Approved on behalf of the Board of Directors:

The accompanying notes and schedules are part of these financial statements.

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
STATEMENT OF OPERATIONS AND CHANGES IN FUND BALANCES
For the Year Ended March 31, 2014

Statement 2

	Operating Fund			Restricted			
	Budget 2014	2014	2013	Capital Fund 2014	Community Trust Fund 2014	Total 2014	Total 2013
REVENUES							
Ministry of Health - General Revenue Fund	$ 109,101,965	$ 111,685,145	$ 106,920,353	$ 5,317,952	$ -	$ 5,317,952	$ 4,576,000
Other Provincial	1,898,887	1,478,611	1,639,425	336,544	-	336,544	338,008
Federal Government	-	2,582	30,614	-	-	-	-
Patient & Client Fees	8,477,904	8,368,366	8,344,301	-	-	-	-
Out of Province (reciprocal)	488,500	500,959	623,700	-	-	-	-
Out of Country	21,000	23,680	19,366	-	-	-	-
Donations	30,000	22,234	22,490	1,151,336	239,081	1,390,417	3,344,688
Ancillary	795,820	750,541	777,360	-	-	-	-
Investment	175,000	151,849	174,725	53,864	57,969	111,833	151,198
Recoveries	562,541	561,729	864,546	-	-	-	-
Research Grants	-	-	-	-	-	-	-
Other	21,950	129,022	120,182	-	-	-	-
Total revenues	**121,573,567**	**123,674,718**	**119,537,062**	**6,859,696**	**297,050**	**7,156,746**	**8,409,894**
EXPENSES							
Inpatient & resident services							
Nursing Administration	3,589,355	4,813,385	3,674,723	-	-	-	-
Acute	14,572,940	14,852,645	14,761,283	1,638,440	65,881	1,704,322	1,597,939
Supportive	17,735,596	18,395,377	18,048,104	1,258,853	11,445	1,270,298	1,364,658
Integrated	5,540,192	5,622,635	5,525,767	1,177,589	4,219	1,181,808	754,570
Rehabilitation	-	-	-	-	-	-	-
Mental Health & Addictions	-	-	-	-	-	-	-
Total Inpatient & Resident Services	**41,438,083**	**43,684,042**	**42,009,877**	**4,074,883**	**81,545**	**4,156,428**	**3,717,168**
Physician Compensation	**11,450,380**	**10,681,297**	**10,186,055**	-	-	-	-
Ambulatory Care Services	**3,298,133**	**3,132,949**	**3,090,743**	-	-	-	-
Diagnostic & Therapeutic Services	**11,366,274**	**11,219,605**	**10,831,026**	-	-	-	-
Community Health Services							
Primary Health Care	2,633,409	2,589,441	2,570,847		1,000	1,000	462,027
Home Care	7,659,800	7,809,068	7,633,560	-	-	-	-
Mental Health & Addictions	2,834,214	2,630,305	2,798,863	-	-	-	-
Population Health	5,372,537	5,051,423	4,975,349	-	-	-	-
Emergency Response Services	3,708,970	3,840,595	3,839,430	124,570	-	124,570	124,784
Other Community Services	570,046	594,758	593,701	36,325	-	36,325	34,583
Total Community Health Services	**22,778,976**	**22,515,590**	**22,411,750**	**160,895**	**1,000**	**161,895**	**621,393**
Support Services							
Program Support	7,625,799	7,748,031	6,748,866	-	-	-	-
Operational Support	22,431,475	23,502,629	22,712,153	92,649	-	92,649	100,579
Employee Future Benefits	-	(35,700)	(38,600)	-	-	-	-
Other Support	463,754	439,999	440,270	-	-	-	-
Total Support Services	**30,521,028**	**31,654,959**	**29,862,689**	**92,649**	-	**92,649**	**100,579**
Ancillary	-	-	-	-	-	-	-
Total Expenses (Schedule 1)	**120,852,874**	**122,888,442**	**118,392,140**	**4,328,427**	**82,545**	**4,410,973**	**4,439,140**
Excess (Deficiency) of Revenues over Expenses	**$ 720,693**	**786,276**	**1,144,922**	**2,531,269**	**214,504**	**2,745,773**	**3,970,754**
Interfund Transfers							
Building renovations (EPC Loan Payments)		(190,197)	(180,346)	190,197	-	190,197	180,346
Capital asset purchases		-	-	787,881	(787,881)	-	-
SHC reserves		(170,357)	(140,148)	170,357	-	170,357	140,148
Capital Equipment		-	(375,000)	-	-	-	375,000
Mortgage payments		(394,223)	(392,364)	394,223	-	394,223	392,364
Total Interfund Transfers		(754,777)	(1,087,859)	1,542,659	(787,881)	754,777	1,087,858
Increase (Decrease) in Fund Balances		**31,499**	**57,063**	**4,073,928**	**(573,377)**	**3,500,551**	**5,058,612**
Fund balances, beginning of year		(5,678,021)	(5,735,084)	48,562,797	4,092,946	52,655,743	47,597,131
Fund balances, end of year		$ (5,646,522)	$ (5,678,021)	$ 52,636,725	$ 3,519,569	$ 56,156,294	$ 52,655,743

The accompanying notes and schedules are part of these financial statements.

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
STATEMENT OF CASH FLOW
For the Year Ended March 31, 2014

Statement 3

	Operating Fund		Restricted Fund			
	2014	2013	Capital Fund	Community Trust Fund	Total 2014	Total 2013
Cash Provided by (used in):	**Operating Activities**		**Financing and Investing Activities**			
Excess (deficiency) of revenue over expenditure	$ 786,276	$ 1,144,922	$ 2,531,269	$ 214,504	$ 2,745,773	$ 3,970,754
Net change in non-cash working capital (Note 7)	1,556,811	(593,370)	3,278,493	-	3,278,493	(2,580,198)
Amortization of capital assets	-	-	4,053,377	-	4,053,377	4,088,098
Investment income on long-term investments	-	-	-	-	-	-
(Gain)/loss on disposal of capital assets	-	-	-	-	-	(3,699)
	2,343,087	551,552	9,863,139	214,504	10,077,644	5,474,955
Purchase of capital assets						
Buildings/construction	-	-	(8,338,546)	-	(8,338,546)	(7,850,680)
Equipment	-	-	(1,984,173)	-	(1,984,173)	(1,724,307)
Proceeds on disposal of capital assets						
Buildings	-	-	-	-	-	-
Equipment	-	-	-	-	-	76,000
Sale (Purchase) of long-term investments	(2,236)	(34,733)	-	-	-	-
	(2,236)	(34,733)	(10,322,719)	-	(10,322,719)	(9,498,987)
Financing activities						
Long-term debt issued	-	-	-	-	-	-
Repayment of debt	-	-	(663,412)	-	(663,412)	(633,263)
	-	-	(663,412)	-	(663,412)	(633,263)
Net increase (decrease) in cash & short-term investments during the year	2,340,851	516,819	(1,122,992)	214,504	(908,488)	(4,657,295)
Cash & short-term investments, beginning of year	8,372,227	8,943,267	4,878,290	4,092,946	8,971,236	12,540,672
Interfund transfers (Statement 2)	(754,777)	(1,087,859)	1,542,659	(787,881)	754,777	1,087,859
Cash & short-term investments, end of year	$ 9,958,300	$ 8,372,227	$ 5,297,957	$ 3,519,569	$ 8,817,526	$ 8,971,236

The accompanying notes and schedules are part of these financial statements.

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
NOTES TO THE FINANCIAL STATEMENTS
As at March 31, 2014

1. Legislative Authority

The Kelsey Trail Regional Health Authority (RHA) operates under *The Regional Health Services Act* (The Act) and is responsible for the planning, organization, delivery, and evaluation of health services it is to provide within the geographic area known as the Kelsey Trail Health Region, under section 27 of The Act. The Kelsey Trail RHA is a non-profit organization and is not subject to income and property taxes from federal, provincial, and municipal levels of government. The RHA is a registered charity under the *Income Tax Act* of Canada.

2. Significant Accounting Policies

These financial statements have been prepared in accordance with Canadian Public Sector Accounting (PSA) standards, issued by the Public Sector Accounting Board and published by CPA Canada. The RHA has adopted the standards for government not-for-profit organizations, set forth at PSA Handbook section PS 4200 to PS 4270.

a) Health Care Organizations

i) The RHA has agreements with and grants funding to the following prescribed HCOs and third parties to provide health services:

Nipawin Oasis Community Centre Co-operative Ltd.
Kelvington Ambulance Care Ltd.
Tisdale Ambulance Care Ltd.
Shamrock Ambulance Care Ltd.
North East EMS
Melfort Ambulance Service
Town of Naicam

Note 9 b) i) provides disclosure of payments to prescribed HCOs and third parties.

ii) Fund Raising Foundations

The Nipawin Region Health Foundation Inc. and the North Central Health Care Foundation Inc. are incorporated under *The Non-Profit Corporations Act* and are registered charities under *The Income Tax Act of Canada*.

Under the Foundations' Articles of Incorporation, all funds raised by the Foundations after payments of reasonable expenses must be paid to the RHA (or must be used to purchase and transfer assets to the RHA, for the purpose to provide health care services.)

These financial statements do not include the financial activities of the two Foundations. Alternatively, Note 9 b) ii) provides supplementary information on the Foundations.

2. Significant Accounting Policies – continued

b) Fund Accounting

The accounts of the RHA are maintained in accordance with the restricted fund method of accounting for revenues. For financial reporting purposes, accounts with similar characteristics have been combined into the following major funds:

i) Operating Fund

The operating fund reflects the primary operations of the RHA including revenues received or receivable for provision of health services from the Ministry of Health - General Revenue Fund, and billings to patients, clients, the federal government and other agencies for patient and client services. Other revenue consists of donations, recoveries and ancillary revenue. Expenses are for the delivery of health services.

ii) Capital Fund

The capital fund is a restricted fund that reflects the equity of the RHA in capital assets after taking into consideration any associated long-term debt. The capital fund includes revenues received or receivable from the Ministry of Health – General Revenue Fund provided for construction of capital projects and/or the acquisition of capital assets. The capital fund also includes donations designated for capital purposes by the contributor. Expenses consist primarily of amortization of capital assets.

iii) Community Trust Fund

The community trust fund is a restricted fund that reflects community generated assets transferred to the RHA in accordance with the pre-amalgamation agreements signed with the amalgamating health corporations. The assets include cash and investments initially accumulated by the health corporations in the RHA from donations or municipal tax levies. These assets are accounted for separately and use of the assets is subject to restrictions set out in pre-amalgamation agreements between the RHA and the health corporations.

c) Revenue

Unrestricted revenues are recognized as revenue in the Operating Fund in the year received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

2. Significant Accounting Policies – continued

Restricted revenues related to general operations are recorded as deferred revenue and recognized as revenue of the Operating Fund in the year in which the related expenses are incurred. All other restricted revenues are recognized as revenue of the appropriate restricted fund in the year.

d) Capital Assets

Capital assets are recorded at cost. Normal maintenance and repairs are expensed as incurred. Capital assets, with a life exceeding one year, are amortized on a straight-line basis over their estimated useful lives as follows:

Land improvements	1 - 20%
Buildings	2.5 - 10%
Equipment	3 – 33.33%

Donated capital assets are recorded at their fair value at the date of contribution (if fair value can be reasonably determined).

e) Inventory

Inventory consists of general stores, pharmacy, laboratory, linen and other. All inventories are held at the lower of cost or net realizable value as determined on a weighted average cost basis.

f) Employee Future Benefits

i) Pension

Employees of the RHA participate in several multi-employer defined benefit pension plans or a defined contribution plan. The RHA follows defined contribution plan accounting for its participation in the plans. Accordingly, the RHA expenses all contributions it is required to make in the year.

ii) Accumulated Sick Leave Benefit Liability

The RHA provides sick leave benefits for employees that accumulate but do not vest. The RHA recognizes a liability and an expense for sick leave in the period which employees render services in return for the benefits. The liability and expense is developed using an actuarial cost method.

g) Measurement Uncertainty

These financial statements have been prepared by management in accordance with Canadian Public Sector Accounting standards. In the preparation of financial statements, management makes various estimates and assumptions in determining the reported amounts of assets and liabilities, revenues and expenses and in the disclosure of commitments and contingencies. Changes in estimates and assumptions will occur based on the passage of time and the occurrence

2. Significant Accounting Policies – continued

of certain future events. The changes will be reported in earnings in the period in which they become known.

h) Financial Instruments

The RHA has classified its financial instruments into one of the following categories: fair value or cost or amortized cost.

All financial instruments are measured at fair value upon initial recognition. The fair value of a financial instrument is the amount at which the financial instrument could be exchanged in an arm's length transaction between knowledgeable and willing parties under no compulsion to act. The following financial instruments are subsequently measured at cost or amortized cost:

- Accounts receivable
- Short term and long term investments
- Accounts payable, accrued salaries and vacation payable
- Long term debt

As at March 31, 2014 the RHA does not have any material outstanding contracts or financial instruments with embedded derivatives.

All financial assets are assessed for impairment on an annual basis. When a decline is determined to be other than temporary, the amount of the loss is reported in the statement of operations.

i) Replacement Reserves

The RHA is required to maintain certain replacement reserves as a condition of receiving subsidy assistance from Saskatchewan Housing Corporation. Schedule 4 shows the changes in these reserve balances during the year.

j) Volunteer Services

The operations of the RHA utilize services of many volunteers. Because of the difficulty in determining the fair market value of these donated services, the value of these donated services is not recognized in the financial statements.

3. Capital Assets

	2014			2013
	Cost	**Accumulated Amortization**	**Net Book Value**	**Net Book Value**
Land	$ 639,590	$ -	$ 639,590	$ 639,590
Land Improvements	687,297	649,788	37,509	41,818
Buildings	116,347,837	67,334,067	49,013,770	31,999,141
Equipment	26,966,524	19,237,138	7,729,386	7,682,973
Construction in progress	250,633	-	250,633	11,038,024
	$ 144,891,881	$ 87,220,993	$ 57,670,888	$ 51,401,546

4. Commitments

a) Capital Asset Obligations

As at March 31, 2014 contractual obligations for acquisition of capital assets were $1,500,604 (2013 - $7,698,905)

b) Operating Leases

Minimum annual payments under operating leases on property and equipment over the next five years are as follows:

2015	$166,075
2016	142,857
2017	63,841
2018	18,663
2019	0

c) Contracted Health Care Organizations

The RHA continues to contract on an ongoing basis with private health service operators to provide health services in the RHA similar to those provided in the year ending March 31, 2013. Note 9 b) provides supplementary information on Health Care Organizations.

5. Long Term Debt

Title of Issue	Interest Rate	Annual Repayment Terms	Balance Outstanding 2014	2013
Rose Valley Health Centre				
C.M.H.C., due October 1, 2021	4.54%	$43,335 Principal & interest Of which $11,063 is subsidized by SHC. Yielding an effective interest rate of 3.38%. Mortgage renewal date – February 1, 2015.	277,861	307,955
Newmarket Manor				
C.M.H.C., due March 1, 2023	4.54%	$160,042 Principal & interest Of which $41,658 is subsidized by SHC. Yielding an effective interest rate of 3.36%. Mortgage renewal date – February 1, 2015.	1,182,037	1,286,337
Kelvindell Lodge				
C.M.H.C., due October 1, 2020	2.11%	$36,129 Principal & interest Of which $8,807 is subsidized by SHC. Yielding an effective interest rate of 1.60%. Mortgage renewal date – January 1, 2019.	205,838	232,297
Red Deer Nursing Home				
C.M.H.C., due February 1, 2027	4.42%	$57,305 Principal & interest Of which $48,000 is subsidized by SHC. Yielding an effective interest rate of 0.72%. Mortgage renewal date – March 1, 2017.	564,605	596,415

5. Long Term Debt – continued

Title of Issue	Interest Rate	Annual Repayment Terms	Balance Outstanding 2014	2013
Arborfield Special Care Lodge				
C.M.H.C., due September 1, 2021	4.54%	$113,245 Principal & interest Of which $33,189 is subsidized by SHC. Yielding an effective interest rate of 3.21%. Mortgage renewal date – February 1, 2015.	719,344	798,285
Pineview Lodge				
C.M.H.C., due January 1, 2017	4.17%	$66,772 Principal & interest Of which $13,827 is subsidized by SHC. Yielding an effective interest rate of 3.31%. Mortgage renewal date – October 1, 2015.	178,220	236,307
C.M.H.C., due April 1, 2025	4.17%	$143,174 Principal & interest Of which $108,000 is subsidized by SHC. Yielding an effective interest rate of 1.02%. Mortgage renewal date – October 1, 2015.	1,271,125	1,359,734
Chateau Providence				
C.M.H.C., due October 1, 2026	4.31%	$96,109 Principal & interest Of which $72,000 is subsidized by SHC. Yielding an effective interest rate of 1.08%. Mortgage renewal date – December 1, 2016.	934,098	989,013
Energy Performance Contract				
Toronto Dominion Bank due October 15, 2026	5.33%	$413,885 Principal and interest	4,092,912	4,283,110
			9,426,040	10,089,453
Less: Current portion			673,801	643,113
			$ 8,752,239	$ 9,446,340

5. Long Term Debt – continued

Saskatchewan Housing Corporation (SHC) may provide a mortgage subsidy for supportive care homes financed by Canada Mortgage and Housing Corporation (CMHC). The subsidy may change when the mortgage renewal occurs.

For each of the mortgages, the RHA has pledged the related buildings of the special care homes as security. The term loan with the Toronto Dominion Bank is unsecured. Principal repayments required in each of the next five years are estimated as follows:

2015	$673,801
2016	726,172
2017	760,004
2018	795,481
2019	832,652
2020 and subsequent	5,637,930

6. Deferred Revenue

As at March 31, 2014	Balance Beginning Of Year	Less Amount Recognized	Add Amount Received	Balance End Of Year
Sask Health Initiatives				
Enhanced Dental Services	$ 19,098	$ 50,498	$ 31,400	$ -
Infection Prevention and Control	67,233	67,233	-	-
LTC - Urgent Issues Action Fund	-	59,907	122,164	62,257
Nursing Recruitment Funding	82,236	-	-	82,236
Physician Recruitment Pilot	50,000	33,333	-	16,667
Primary Care - Physician Alternate Payment	960,708	8,420,572	7,960,000	500,136
Primary Care - Melfort PHC Team	-	-	125,000	125,000
Pharmacist Services	118,608	118,608	-	-
Surgical Initiative	436,465	436,465	-	-
Total Sask Health	**1,734,348**	**9,186,616**	**8,238,564**	**786,295**
Non Sask Health Initiatives				
Kids First Targeted	318,270	586,646	569,622	301,246
Total Non Sask Health	**318,270**	**586,646**	**569,622**	**301,246**
Total Deferred Revenue	**$ 2,052,618**	**$ 9,773,262**	**$ 8,808,186**	**$ 1,087,541**

6. Deferred Revenue – continued

As at March 31, 2013	Balance Beginning Of Year	Less Amount Recognized	Add Amount Received	Balance End Of Year
Sask Health Initiatives				
Enhanced Dental Services	29,145	10,047	-	19,098
Infection Prevention and Control	52,780	31,632	46,085	67,233
Nursing Professional Development	7,858	7,858	-	-
Nursing Recruitment Funding	125,424	43,188	-	82,236
Physician Recruitment Pilot	100,000	50,000	-	50,000
Primary Care	958,128	7,714,169	7,716,749	960,708
Pharmacist Services	92,372	53,764	80,000	118,608
Surgical Initiative	186,000	87,120	337,585	436,465
Total Sask Health	**1,551,707**	**7,997,778**	**8,180,419**	**1,734,347**
Non Sask Health Initiatives				
Enhanced Dental Services	25,637	25,637	-	-
Kids First Targeted	249,069	496,599	565,800	318,270
Lean	36,052	36,052	-	-
Total Non Sask Health	**310,758**	**558,288**	**565,800**	**318,270**
Total Deferred Revenue	**$ 1,862,465**	**$ 8,556,066**	**$ 8,746,219**	**$ 2,052,617**

7. Net Change in Non-cash Working Capital

	Operating Fund		Restricted Funds			
	2014	2013	Capital Fund	Community Trust Fund	Total 2014	Total 2013
(Increase) Decrease in accounts receivable	$ (66,476)	$ (180,850)	$ 2,221,697	$ -	$ 2,221,697	$ (2,757,275)
(Increase) Decrease in inventory	(10,291)	10,003	-	-	-	-
(Increase) Decrease in prepaid expenses	55,536	51,216	-	-	-	-
Increase (Decrease) in accounts payable	(387,808)	(626,771)	1,056,796	-	1,056,796	177,077
Increase (Decrease) in accrued salaries	2,719,141	251,473	-	-	-	-
Increase (Decrease) in vacation payable	247,485	(249,993)	-	-	-	-
Increase (Decrease) in deferred revenue	(965,076)	190,152	-	-	-	-
Increase (Decrease) in employee future benefits	(35,700)	(38,600)	-	-	-	-
	$ 1,556,811	$ (593,370)	$ 3,278,493	$ -	$ 3,278,493	$ (2,580,198)

8. Patient and Resident Trust Accounts

The RHA administers funds held in trust for patients and residents using the RHA's facilities. The funds are held in separate accounts for the patients or residents at each facility. The total cash held in trust as at March 31, 2014 was $49,954 (2013 - $46,159). These amounts are not reflected in the financial statements.

9. Related Parties

These financial statements include transactions with related parties. The RHA is related to all Saskatchewan Crown Agencies such as ministries, corporations, boards, and commissions under the common control of the Government of Saskatchewan. The RHA is also related to non-Crown enterprises that the Government jointly controls or significantly influences. In addition, the RHA is related to other non-Government organizations by virtue of its economic interest in these organizations.

a) Related Party Transactions

Transactions with these related parties are in the normal course of operations. Amounts due to or from and the recorded amounts of transactions resulting from these transactions are included in the financial statements and the table below. They are recorded at exchange amounts which approximate prevailing market rates charged by those organizations and are settled on normal trade terms.

In addition, the RHA pays Provincial Sales Tax to the Saskatchewan Ministry of Finance on all its taxable purchases. Taxes paid are recorded as part of the cost of those purchases.

	2014	2013
Revenues		
Athabasca Regional Health Authority	$ 88,066	$ 141,879
Ministry of Education	645,007	640,565
Ministry of Health	117,003,097	111,496,353
Ministry of Justice	100,000	100,000
Sask Housing Corporation	336,544	338,007
SGI	95,495	95,506
	$ 118,268,209	$ 112,812,310

9. Related Parties - continued

Expenditures	2014	2013
Correctional Facilities Industries Revolving Fund	$ 506	$ -
Cumberland Regional College	8,179	1,600
Health Quality Council	4,604	6,549
Heartland Health Region	-	145
Mamawetan Churchill River Regional Health Authority	8,520	8,220
Ministry of Government Services	651,630	599,332
North East School Division	40,454	44,261
North Sask Laundry & Support Services	802,970	688,310
Prince Albert Parkland Regional Health Authority	72,395	15,414
Regina Qu'appelle Regional Health Authority	3,326	53
3sHealth	3,961,726	3,813,964
Sask Energy	1,174,213	1,145,083
Sask Housing	16,939	55,086
Sask Power	1,207,813	1,139,047
Sask Rivers Public School Division	-	65
Sask Tel	750,760	767,397
Sask Workers Compensation Board	1,013,304	1,925,766
Saskatchewan Institute of Applied Science and Technology	3,859	3,778
Saskatchewan Transport Company	16,941	13,304
Saskatoon Regional Health Authority	341,271	339,321
SGI	9,951	10,452
SHEPP	11,417,441	10,469,414
Sunrise Regional Health Authority	52	402
Community Initiatives Fund	1,250	-
Cyress Regional Health Authority	200	-
eHealth Saskatchewan	175,102	204,256
Five Hills Regional Health Authority	1,050	81
Holy Trinity School Division	125	-
Physician Recruitment Agency of Saskatchewan	100	110
Saskatchewan Research Council	377	348
Information Services Corporation	20	-
Public Employees Benefits Agency	26,412	-
Queens Printer	5,723	-
Sask Liquor and Gaming Authority	1,381	-
	$ 21,718,594	$ 21,251,757

9. Related Parties - continued

	2014	2013
Accounts Receivable		
Ministry of Health	$ 655,443	$ 2,625,860
	$ 655,443	$ 2,625,860
Prepaid Expenditures		
Workers Compensation	$ 317,735	$ 322,376
	$ 317,735	$ 322,376
Accounts Payable		
Ministry of Health	$ -	$ 181,034
	$ -	$ 181,034

b) Health Care Organizations

i) Prescribed Health Care Organizations and Third Parties

The RHA has also entered into agreements with prescribed HCOs and Third Parties to provide health services.

These organizations receive operating funding from the RHA on a monthly basis in accordance with budget amounts approved annually. During the year, the RHA provided the following amounts to prescribed HCOs and Third Parties:

	2014	2013
Nipawin Oasis Community Centre Co-operative Ltd.	$ 53,959	$ 56,752
Kelvington Ambulance Care Ltd.	421,917	419,495
Tisdale Ambulance Care Ltd.	492,292	495,131
Shamrock Ambulance Care Ltd.	233,892	233,892
North East EMS	1,020,165	1,021,285
Melfort Ambulance Service	502,691	503,431
Town of Naicam	137,457	154,055
	$ 2,862,373	$ 2,884,041

ii) Fund Raising Foundations

Fund raising efforts are undertaken through non-profit business corporations known as the Nipawin Region Health Foundation Inc. and North Central Health Care Foundation Inc. The Kelsey Trail Regional Health Authority has an economic interest in the Foundations. In accordance with donor-imposed restrictions, $476,122 (2013 - $272,835) of the foundations' net assets must be used to purchase specialized equipment or services. The Nipawin Region Health Foundation Inc. total expenses include contributions of $66,017 (2013 - $54,353) to the RHA. The North Central Health Care Foundation Inc. total expenses include contributions of $43,750 (2013 - $0) to the RHA.

10. Employee Future Benefits

a) Pension Plan

Employees of the RHA participate in one of the following pension plans:

1. Saskatchewan Healthcare Employees' Pension Plan (SHEPP) - This is jointly governed by a board of eight trustees. Four of the trustees are appointed by the Health Shared Services Saskatchewan (3sHealth) (a related party) and four of the trustees are appointed by Saskatchewan's health care unions (CUPE, SUN, SEIU, SGEU, RWDSU, and HSAS). SHEPP is a multi-employer defined benefit plan, which came into effect December 31, 2002. (Prior to December 31, 2002, this plan was formerly the SAHO Retirement Plan and governed by the 3sHealth Board of Directors).

2. Public Service Superannuation Plan (PSSP) (a related party) - This is also a defined benefit plan and is the responsibility of the Province of Saskatchewan.

3. Public Employees' Pension Plan (PEPP) (a related party) - This is a defined contribution plan and is the responsibility of the Province of Saskatchewan.

The RHA's financial obligation to these plans is limited to making required payments to these plans according to their applicable agreements. Pension expense is included in Compensation – Benefits in Schedule 1 and is equal to the RHA contributions amount below.

	2014			2013
	SHEPP[1]	PEPP	Total	Total
Number of active members	1,358	6	1,364	1,364
Member contribution rate, percentage of salary	7.70%-10.00%	5.00-7.00%*		
RHA contribution rate, percentage of salary	8.62%-11.20%	5.00-7.00%*		
Member contributions (thousands of dollars)	5,020	33	5,053	4,975
RHA contributions (thousands of dollars)	5,623	33	5,655	5,571

*Contribution rate varies based on employee group

1. Active members are employees of the RHA, including those on leave of absense as of March 31, 2014.
Inactive members are not reported by the RHA, their plans are transferred to SHEPP and managed directly by them.

Pension plan contribution rates have increased as a result of recent deficiencies in SHEPP. Any actuarially determined deficiency is the responsibility of participating employers and employees in the ratio of 1.12 to 1. Contribution rates will continue to increase until the next actuarial reports are completed.

10. Employee Future Benefits - continued

b) Accumulated Sick Leave Benefit Liability

The cost of the accrued benefit obligations related to sick leave entitlement earned by employees is actuarially determined using projected benefit method prorated on service and management's best estimate of inflation, discount rate, employee demographics and sick leave usage of active employees. The RHA has completed an actuarial valuation as of March 31, 2013, with an estimated valuation to March 31, 2014. Key assumptions used as inputs into the actuarial calculation are as follows:

	2014	2013
Discount rate	2.50%	2.50%
Earnings Increase	0% - 2%	0% - 2%

		2014		2013
Accrued benefit obligation, beninng of year	$	4,149,100	$	4,187,700
Cost for the year		601,100		591,900
Benefits paid during the year		(636,800)		(630,500)
Accrued benefit obligation, end of year	$	4,113,400	$	4,149,100

11. Budget

The RHA Board approved the 2013-2014 budget plan on June 10, 2013.

12. Financial Instruments

a) Significant Terms and Conditions

There are no significant terms and conditions related to financial instruments classified as current assets or current liabilities that may affect the amount, timing, and certainty of future cash flows. Significant terms and conditions for the other financial instruments are disclosed separately in these financial statements.

b) Financial Risk Management

The RHA has exposure to the following risk from its use of financial instruments: credit risk, market risk and liquidity risk.

The Board ensures that the RHA has identified its major risks and ensures that management monitors and controls them. The Chairperson oversees the RHA's systems and practices of internal control, and ensures that these controls contribute to the assessment and mitigation of risk.

12. Financial Instruments - continued

c) Credit Risk

The RHA is exposed to credit risk from the potential non-payment of accounts receivable. The RHA is also exposed to credit risk from cash, short-term investments and investments.

The carrying amount of financial assets represents the maximum credit exposure as follows:

		2014		2013
Cash and short-term investments	$	18,775,826	$	17,343,464
Accounts receivable				
Ministry of Health - General Revenue Fund		655,443		2,625,860
Other		1,327,314		1,512,117
Investments		1,222,537		1,221,325
	$	21,981,120	$	22,702,766

The RHA manages its credit risk surrounding cash and short-term investments and investments by dealing solely with reputable banks and financial institutions, and utilizing an investment policy to guide their investment decisions. The RHA invests surplus funds to earn investment income with the objective of maintaining safety of principal and providing adequate liquidity to meet cash flow requirements.

d) Market Risk

Market risk is the risk that changes in market prices, such as foreign exchange rates or interest rates, will affect the RHA's income or the value of its holdings of financial instruments. The objective of market risk management is to control market risk exposures within acceptable parameters while optimizing return on investment

i) Foreign Exchange Risk:

The RHA operates within Canada, but in the normal course of operations is party to transactions denominated in foreign currencies. Foreign exchange risk arises from transactions denominated in a currency other than the Canadian dollar, which is the functional currency of the RHA. The RHA believes that it is not subject to significant foreign exchange risk from its financial instruments.

12. Financial Instruments - continued

ii) Interest Rate Risk:

Interest rate risk is the risk that the fair value of future cash flows or a financial instrument will fluctuate because of changes in the market interest rates.

Financial assets and financial liabilities with variable interest rates expose the RHA to cash flow interest rate risk. The RHA's investments include long-term bonds bearing interest at coupon rates. The RHA's long-term debt outstanding as at March 31, 2014 and 2013 have fixed interest rates.

Although management monitors exposure to interest rate fluctuations, it does not employ any interest rate management policies to counteract interest rate fluctuations.

As at March 31, 2014, had prevailing interest rates increased or decreased by 1%, assuming a parallel shift in the yield curve, with all other variables held constant, the RHA's financial instruments would have decreased or increased by approximately $45,000, (2013 - $46,000) approximately 4% of the fair value of investments (2013 – 4%).

e) Liquidity Risk

Liquidity risk is the risk that the RHA will not be able to meet its financial obligations as they become due.

The RHA manages liquidity risk by continually monitoring actual and forecasted cash flows from operations and anticipated investing and financing activities.

At March 31, 2014 the RHA has an operating cash balance of $9,958,301 (2013 - $8,372,228).

f) Fair Value

The carrying amounts of these financial instruments approximate fair value due to their immediate or short-term nature:

- Cash and short-term investments
- Accounts receivable
- Accounts payable
- Accrued salaries and vacation payable

12. Financial Instruments - continued

The carrying amount of investments approximates their fair value as interest rates are consistent with current market rates.

The fair value of mortgage payable and long term debt before the repayment required within one year is $10,218,960 (2013 $7,225,829) and is determined using discounted cash flow analysis based on current incremental borrowing rates for similar borrowing arrangements, net of mortgage subsidies.

g) Short-term Borrowing/Operating Line-of-credit

The RHA has a line-of-credit of $1,000,000 (2013 - $1,000,000) with a floating rate of interest charged at Prime minus .50% which is re-negotiated annually. The line-of-credit is secured by accounts receivable including all grants, revenues and any other forms or sources of payments from the Province of Saskatchewan and any other funding bodies. Total interest paid on the line-of-credit was $0 (2013 - $0).

13. Community Generated Funds

Under the terms of the pre-amalgamation agreement, the RHA has agreed to hold community generated assets in trust. The Board established a separate fund for the assets of each trust. Health corporations formerly held these assets before amalgamating with the Board. The assets are interest bearing with the interest credited to the trust balance. The Authority presently administers $3,519,569 (2013 - $4,092,946) under these agreements.

Each trust fund has a "Trust Advisory Committee" which is appointed by the various towns, villages, hamlets, and rural municipalities served by the pre-amalgamation agency. The trust funds are for the benefit of the ratepayers of the various municipalities and shall be used for health related purposes. The committees have the power to establish rules and procedures and the majority decision of the committees shall be binding upon the RHA with respect to any use of the trust fund.

14. Energy Performance Contract

Energy performance contracting is a unique program that allows the RHA to implement facility improvements, reduces energy costs, improve health and comfort conditions while contributing to the province's environmental objectives. *SaskPower Energy Solutions* performed extensive research to establish a baseline of annual cost savings they guarantee as part of this project. The project is expected to provide utility cost savings that will pay for the cost and financing of this project within an established time frame. Any additional savings are calculated and verified by methods established in the contract and are applied to the loan. Kelsey Trail Regional Health Authority entered into a guaranteed energy performance savings contract with *SaskPower Energy Solutions Company*.

14. Energy Performance Contract - continued

The total cost of the energy performance contract is $4,861,669. As at March 31, 2014, construction costs of $4,785,198 (2013 - $4,785,198) have been financed through a $4,861,669 long-term debt loan with a balance of $4,092,912 outstanding (2013 - $4,283,110), which bears interest at a rate of 5.33%. The long-term debt is amortized over a period of 18.5 years.

Results of the energy renewal project since its inception are:

	2014	Prior Years	Total
Estimated Utility Savings	394,983	886,065	1,281,048
Interest Costs	223,688	835,548	1,059,236

15. Collective Agreements

The SGEU contract expired March 31,2012 and was settled February 2014. The SGEU retroactive settlement and related funding have been recorded in the financial statements. The SUN contract expired March 31, 2014 and the HSAS contract expired March 31, 2013 and negotiations are in the early stages and an estimate of the settlements is not determinable at this time.

16. Pay for Performance

Effective April 1st, 2011, a pay performance compensation plan was introduced. Amounts over 90% of base salary are considered 'lump sum performance adjustments'. Senior employees are eligible to earn lump sum performance adjustments up to 110% of their base salary. During the year, senior employees are paid 90% of current year base salary and lump sum performance adjustments related to the previous fiscal year. At March 31, 2014 lump sum performance adjustments relating to 2013-14 have not been determined as information required to assess senior employee performance is not yet available.

17. Comparative Figures

Certain of the prior year figures have been reclassified to conform to the current year's presentation.

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
SCHEDULE OF EXPENSES BY OBJECT
For the Year Ended March 31, 2014

Schedule 1

	Budget 2014	Actual 2014	Actual 2013
Operating:			
Advertising & public relations	$ 98,775	$ 165,416	$ 106,360
Board costs	117,210	126,846	123,949
Compensation - benefits	14,163,477	14,383,363	14,506,462
Compensation - employee future benefits	-	(35,700)	(38,600)
Compensation - salaries	73,360,914	76,195,144	73,271,241
Continuing education fees & materials	290,925	225,642	207,784
Contracted-out services - Other	277,487	242,371	326,214
Diagnostic imaging supplies	20,820	16,488	14,931
Dietary supplies	129,914	134,903	127,092
Drugs	630,410	626,741	591,615
Food	1,708,592	1,671,619	1,671,398
Grants to ambulance services	2,790,581	2,790,582	2,790,582
Grants to health care organizations & affiliates	768,835	776,163	669,450
Housekeeping & laundry supplies	305,825	311,018	290,684
Information technology contracts	1,011,950	953,343	831,395
Insurance	249,500	225,427	215,893
Interest	229,352	230,029	239,702
Laboratory supplies	1,145,146	1,122,856	1,063,055
Medical & surgical supplies	2,696,873	2,528,617	2,386,078
Medical remuneration & benefits	11,222,618	10,693,693	10,159,084
Meetings	110,311	47,650	88,485
Office supplies & other office costs	420,151	348,565	399,701
Other	354,258	407,984	311,469
Professional fees	898,221	881,895	813,482
Prosthetics	-	-	-
Purchased salaries	817,064	694,604	520,337
Rent/lease/purchase costs	1,398,866	1,440,900	1,250,386
Repairs & maintenance	1,591,491	1,594,563	1,554,679
Supplies - Other	364,997	384,303	363,488
Therapeutic supplies	-		-
Travel	1,191,100	1,127,944	1,126,237
Utilities	2,487,211	2,575,473	2,409,507
Total Operating Expenses	$ 120,852,874	$ 122,888,442	$ 118,392,140
Restricted:			
Amortization		$ 4,053,377	$ 4,088,098
Loss/(Gain) on disposal of fixed assets		-	(3,700)
Mortgage Interest Expense		257,552	277,456
Other		100,044	77,286
		$ 4,410,973	$ 4,439,140

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
SCHEDULE OF CONSOLIDATED INVESTMENTS
As at March 31, 2014

Schedule 2

		Fair Value	Maturity	Effective Rate	Coupon Rate
Restricted Investments*					
Cash and Short Term					
Chequing and Savings:					
Cornerstone Credit Union - Tisdale	$	8,782,634			
Diamond North Credit Union		34,891			
	$	8,817,526			
Term Deposits:					
		-			
	$	-			
Total Cash & Short Term Investments	$	8,817,526			
Long Term					
		-			
Total Long Term Investments	$	-			
Total Restricted Investments	$	**8,817,526**			
Unrestricted Investments					
Cash and Short Term					
Cash on Hand	$	7,150			
Cornerstone Credit Union - Tisdale		9,677,578			
Advantage Credit Union		98,339			
Diamond North Credit Union		113,313			
Hudson Bay Credit Union		30,766			
Porcupine Credit Union		10,572			
Kelvington Credit Union		20,583			
Total Cash & Short Term Investments	$	9,958,300			
Long Term					
Bonds	$	1,222,537	Various	3.41%	Various
Total Long Term Investments	$	1,222,537			
Total Unrestricted Investments	$	**11,180,837**			
Total Investments	$	**19,998,363**			
Restricted & Unrestricted Totals					
Total Cash & Short Term	$	18,775,826			
Total Long Term		1,222,537			
Total Investments	$	**19,998,363**			

* Restricted Investments consist of:
- Community generated funds transferred to the RHA and held in the Community Trust Fund (Schedule 3); and
- Replacement reserves maintained under mortgage agreements with Canada Mortgage and Housing Corporation (CMHC) held in the Capital Fund (Schedule 4).

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
SCHEDULE OF EXTERNALLY RESTRICTED FUNDS
For the Year Ended March 31, 2014

Schedule 3

COMMUNITY TRUST FUND EQUITY

Trust Name	Balance Beginning of Year	Investment & Other Revenue	Donation	Expenses / Transfers	Capital Expenses	Balance End of Year
Community Services	$ 115,602	$ 1,644	$ 11,695	$ -	$ (14,193)	$ 114,748
Edith Campbell Bursary	23,298	343	2,500	-	-	26,142
Hudson Bay Health Care Facility	220,046	3,141	25,766	(4,219)	(10,054)	234,680
Kelvindell Lodge	127,022	1,742	7,636	(11,445)	(4,633)	120,322
Kelvington Hospital	134,529	1,958	11,999	-	-	148,486
New Market Place	1,045,594	14,833	82,000	(335,405)	(363,023)	443,999
Pam Worley Bursary	800	9	-	(177)	-	632
Porcupine Plain Hospital	236,185	3,474	33,635	(1,515)	(4,555)	267,224
Ralston Medical Research	572,855	7,966	-	(60,000)	-	520,821
Red Deer Nursing Home	57,991	845	9,054	-	(2,481)	65,409
Rose Valley Health Centre	82,383	1,152	-	(1,000)	-	82,535
Tisdale Hospital	1,384,368	19,416	29,618	(4,189)	(53,538)	1,375,675
Tisdale Hospital - Dialysis Unit	92,273	1,445	25,179	-	-	118,897
Total Community Trust Fund	**$ 4,092,946**	**$ 57,969**	**$ 239,081**	**$ (417,950)**	**$ (452,476)**	**$ 3,519,569**

CAPITAL FUND

	Balance Beginning of Year	Investment & Other Income	Capital Grant Funding	Expenses / Transfers	Capital Expenses	Balance End of Year
Cumberland House Project	$ 57,194	$ -	$ -	$ (57,194)	$ -	$ -
Energy Performance Contract	76,471	-	-	(76,471)	-	-
Ministry of Health - Block Funding	334,057	-	280,000	-	(369,578)	244,479
Ministry of Health - Capital Equipment	273,027	-	482,836	-	(344,202)	411,661
Ministry of Health - Capital Projects	2,693,489	1,066,733	4,555,116	335,405	(8,338,547)	312,196
Ministry of Health - CT Project	429,400	-	-	-	-	429,400
Ministry of Health - Radiology Equipment	796,053	-	-	-	(134,562)	661,492
Ministry of Health - Safety and Surgical	389,047	-	-	-	(176,698)	212,349
Other	109,438	77,249	-	(185)	(87,349)	99,153
Total Capital Fund	**$ 5,158,176**	**$ 1,143,981**	**$ 5,317,952**	**$ 201,556**	**$ (9,450,936)**	**$ 2,370,729**

TOTAL EXTERNALLY RESTRICTED FUNDS	**$ 9,251,122**	**$ 1,201,950**	**$ 5,557,033**	**$ (216,395)**	**$ (9,903,412)**	**$ 5,890,298**

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
SCHEDULE OF INTERNALLY RESTRICTED FUND BALANCES
For the Year Ended March 31, 2014

Schedule 4

	Balance, beginning of year	Investment income allocated	Annual allocation from unrestricted fund	Transfer to unrestricted fund (expenses)	Capital Expenses	**Balance, end of year**
Capital						
Replacement Reserves						
Arborfield Special Care Home	$ 132,432	$ 1,797	$ 9,915		$ (12,324)	$ 131,820
Chateau Providence	52,376	744	7,750			60,871
Kelvindell Lodge	80,691	975	8,043		(27,293)	62,416
Newmarket Manor	197,957	2,814	18,000			218,771
Pineview Lodge	4,745	67	11,254			16,066
Red Deer Nursing Home	53,258	754	2,294		(2,424)	53,882
Total Replacement Reserves	$ 521,459	$ 7,152	$ 57,256	$ -	$ (42,041)	$ 543,826
Other Internally Restricted Funds						
Activities - Arborfield Special Care Home	11,248	6,560		(5,638)		12,171
Activities - Carrot River	23,546	9,558		(11,861)		21,244
Ambulances	101,616	1,444	50,000			153,060
Capital	686,926	26,203		133,664	(350,252)	496,541
Cumberland House Health Centre	25,273	359	7,500			33,132
Cumberland House Home Care	22,167	312				22,479
Hudson Bay Health Care Facility	49,720	707	5,080			55,507
Newmarket Manor - Floor Account	250,910	3,535				254,445
Nirvana Pioneer Villa	57,212	813	12,000			70,026
Palliative Home Care	4,247	53			(2,824)	1,477
Parkland	207,483	2,850	20,000		(22,556)	207,777
Pasquia Special Care Home	51,295	727	5,800		(1,635)	56,188
Rose Valley Health Centre	66,591	947	8,111			75,649
Sasko Park Lodge	7,602	108	4,320			12,030
Tisdale Joint Use Facility	5,233	74	290			5,597
Total Capital	**$ 2,092,529**	**$ 61,404**	**$ 170,357**	**$ 116,166**	**$ (419,307)**	**$ 2,021,149**
Operating						
Other Internally Restricted Funds						
	$ -	$ -	$ -	$ -	$ -	$ -
Total Operating	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Total Internally Restricted Funds	**$ 2,092,529**	**$ 61,404**	**$ 170,357**	**$ 116,166**	**$ (419,307)**	**$ 2,021,149**

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
SCHEDULES OF
BOARD MEMBER REMUNERATION
for the year ended March 31, 2014

Schedule 5(a)

RHA MEMBERS	RETAINER	PER DIEM	TRAVEL TIME EXPENSES	TRAVEL AND SUSTENANCE EXPENSES	OTHER EXPENSES	CPP	2014 TOTAL	2013 TOTAL
Chairperson								
Wilfred Veller[1]	-	-	-	-	-	-	-	2,245
Rennie Harper[2]	9,960	32,958	16,087	-	-	-	59,005	29,694
Board Member								
Rennie Harper[6]	-	-	-	-	-	-	-	10,433
Clarence Hendrickson	-	11,221	7,969	-	-	129	19,319	13,899
Darrell Guy	-	5,813	3,988	-	-	-	9,801	9,330
Kathleen Bedard	-	4,353	2,201	-	-	176	6,730	13,649
Carla Hipkins[4]	-	-	-	-	-	-	-	1,872
Gordon Cresswell	-	4,950	2,194	-	-	-	7,144	9,478
Dennis Koch	-	6,650	3,032	-	-	213	9,895	7,254
Allyson Stevenson[3]	-	-	-	-	-	-	-	295
Frank Garchinski	-	4,145	1,740	-	-	-	5,885	8,915
Cheryl Watt[7]	-	-	-	-	-	-	-	365
Rhonda Desjarlais[3,5]	-	-	-	-	-	-	-	929
Richard Radom[3]	-	3,678	2,072	-	-	212	5,962	8,733
Nancy Steinbachs[3]	-	4,213	2,794	-	-	89	7,096	9,601
Vacant Position	-	-	-	-	-	-	-	-
TOTAL	**9,960**	**77,981**	**42,077**	-	-	**819**	**130,837**	**126,692**

[1]Resigned April 23, 2012
[2]Term began April 23, 2012
[3]Term began September 4, 2012
[4]Term ended May 22, 2012
5Resigned December 31, 2012
[6]Term ended April 23, 2012
[7]Term ended April 1, 2012
[7]Term ended April 1, 2012

SENIOR MANAGEMENT SALARIES, BENEFITS, ALLOWANCES, AND SEVERANCE

for the year ended March 31, 2014

Schedule 5 (b)

	2014							2013		
Senior Employees	**Salaries[1]**	**Vacation Payout[1]**	**Sub-total (Total Salaries)**	**Benefits and Allowances[2]**	**Sub-total**	**Severance Amount**	**Total**	**Salaries, Benefits & Allowances[1,2]**	**Severance**	**Total**
Glen Kozak, CEO[5]	$ 207,587	$ 62,535	$ 270,122	$ 2,604	$ 272,726	$ -	272,726	$ 264,448	$ -	$ 264,448
Senior Positions:										
Pam McKay	222,995	14,462	237,457	851	238,308	-	238,308	256,407	-	256,407
VP Institutional & Emergency Care										
Shane Merriman	171,015	20,204	191,219	47	191,266	-	191,266	222,521	-	222,521
VP Corporate Services										
Shane Merriman[6]	66,460	-	66,460	19	66,479	-	66,479	-	-	-
VP Corporate Services & Acting COO										
Julie Clearwley[3]	-	-	-	-	-	131,434	131,434	65,506	-	65,506
VP Community & Primary Health Care										
Richard Peters[4]	139,044	-	139,044	816	139,860	-	139,860	120,877	-	120,877
VP Community & Primary Health Care										
Dr. Wingate	150,342	-	150,342	3,600	153,942	-	153,942	153,942		153,942
VP Medcial Services & Chief of Staff										
Total	**$ 957,443**	**$ 97,201**	**$ 1,054,644**	**$ 7,937**	**$ 1,062,581**	**$ 131,434**	**$ 1,194,015**	**$ 1,083,701**	**$ -**	**$ 1,083,701**

1. Salaries include regular base pay, overtime, honoraria, sick leave, vacation leave, and merit or performance pay, lumpsum payments, and any other direct cash remuneration. Senior employees were paid 90% of base salary. Senior employees are eligible to earn up to 110% of their base salary. Performance pay is reflected in the year paid. Refer to Note 16 for further details.

2. Benefits and Allowances include the employer's share of amounts paid for the employees' benefits and allowances that are taxable to the employee. This includes taxable: professional development, education for personal interest, non-accountable relocation benefits, personal use of: an automobile; cell-phone; computer; etc. As well as any other taxable benefits.

3. Resigned May 9, 2012

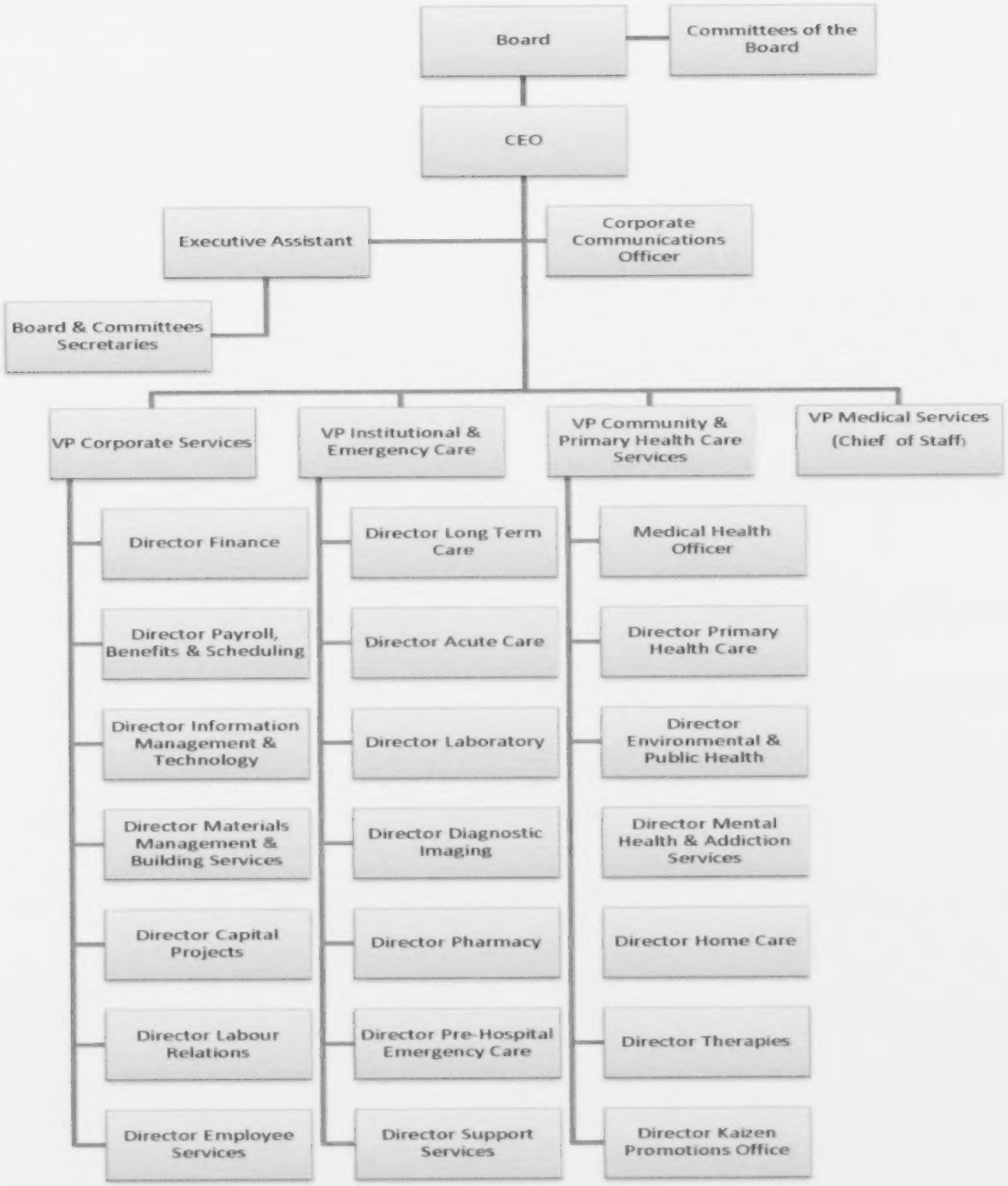
4. Interim position May 14, 2012

5. Retired December 31, 2013

6. Acting COO position began December 13, 2013

Appendices

2013-14 Organizational Chart



KELSEY TRAIL REGIONAL HEALTH AUTHORITY

PAYEE DISCLOSURE LIST
For the Year Ended March 31, 2014

As part of government's commitment to accountability and transparency, the Ministry of Health and Regional Health Authorities disclose payments of $50,000 or greater made to individuals, affiliates and other organizations during the fiscal year. These payments include salaries, contracts, transfers, supply and service purchases and other expenditures.

Listed are individuals who received payments for salaries, wages, honorariums, etc. which total $50,000 or more

Personal Services

Aasen, Corey	$59,158.20	Bayne, Bonny	51,699.63
Aasen, Tammy	79,011.62	Beaulieu, Sharon	$91,064.31
Aasen, Ward	54,790.37	Bedard, Tracy	98,206.50
Adames, Oralee	82,049.85	Bednarz, Amanda	71,347.35
Agur, Jennifer	83,378.47	Beecher, Clint	62,399.44
Alexander, Laura	67,223.62	Bergren, Dorothy	100,010.54
Anderson, Christie	103,859.25	Bertrand, Marilyn	64,709.87
Anderson, Penny	124,076.82	Bigelow, Sharyl	63,921.41
Andrus, Angela	91,735.53	Bischoff, Carrie	92,455.40
Anstey Teichroeb, Kelly	72,542.00	Bittman, Lyle	104,840.15
Arneson, Anna	86,424.87	Bitzer, Denise	113,245.37
Assie, Ramona	123,518.17	Black, Joan	102,533.50
Atkings, Deborah	91,119.77	Blow, Robert	52,134.58
Atkinson, Lorette	69,727.86	Bohmann, Peggy	76,268.42
Audette, Debra	50,706.38	Bolduc, Jennifer	51,503.79
Bagnall, Charlott	58,731.35	Bond, Mary Lou	65,943.73
Ballendine, Laurie	60,440.64	Bonsan, Roxane	96,891.17
Baptist, Farrah	58,578.43	Borsa, Shannon	58,721.45
Baranieski, Cay	57,163.50	Bouvier, Gisele	86,265.44
Barlow, Linda	122,594.31	Boxall, Lia	149,068.56
Batiuk, Carlina	50,244.30	Braaten, Lynda	71,048.68
Bauer, Kama	57,602.12	Bradley, Margaret	91,932.88

Bradshaw, Katherine	95,574.89	Claypool, Renee	77,405.71
Brakstad, Terry	72,955.90	Cleaveley, Julie	131,434.00
Brann, Amy	$70,941.75	Clunie, Rhonda	$50,737.14
Bronner, Tanis	73,372.89	Code, Jacquelin	68,287.71
Brothwell, Linda	113,736.15	Cole, Betty	63,674.38
Brown, Diane	77,676.19	Coleman, Elise	84,133.92
Brown, Tammy	62,244.67	Collins, Beverly	54,297.49
Bryson, Dennis	73,319.96	Connor, Anne	61,297.70
Buhler, Jessie	82,554.02	Cosh, Deena	50,240.40
Burghardt, Shelley	60,188.16	Cressman, Trudy	93,852.18
Burt, Mary	68,445.29	Crickett, Donna	100,011.38
Burton, Violet	93,155.12	Cross, Debbie	59,029.31
Buyaki, Peggy	70,590.06	Currie, Debra	62,513.23
Cal, Shelly	167,461.73	Curry, Meghan	62,071.30
Campbell, Quentin	50,442.54	Cyr, Ron	70,529.95
Campbell, Vivian	118,091.75	Dagg, Arlene	59,779.93
Carlson, Sandra	91,650.19	Dagg, Leslie	92,023.52
Carolus, Andrew	53,706.11	Dahl, Sherry	100,486.14
Carswell, Kathryn	81,427.57	Dalziel, Joan	73,790.25
Casemore, Terrah	69,728.13	Daoust, Roxane	74,140.91
Chabot, Catherine	82,278.77	Davies, Bonita	50,565.35
Chabot, Chelsey	80,379.94	Davis, Andrea	53,089.56
Chaboyer, Sheila	71,401.39	Day, Karen	101,683.27
Chapman, Jeannine	82,789.82	De Haan, Sonya	97,299.35
Charko, Jessie	68,927.16	Dean, Melody	101,803.00
Chatfield, Patty	62,180.66	DeLaet, Erin	78,520.19
Chorney, Jessica	74,739.63	Delwisch, Sandra	71,031.81
Christianson, Leslie	75,963.70	DeMarsh, Terry	97,156.74
Chrusch, Garry	80,182.77	Dierker, Christine	96,062.80
Chrusch, Maureen	98,635.76	Diller, Ronald	104,840.24
Clark, Thomas	90,232.57	Dobrinski, Barb	103,044.15
Clarke, Janice	93,228.84	Dobson, Tina	101,571.06
Clarke, Leeann	79,304.36	Donald, Ronda	112,415.31

Doucette, Delvena	111,148.47	Firman Depeel, Christine	100,739.98
Doucette, Natalie	104,139.45	Flamand, Sonia	63,084.37
Douslin, Sharon	$81,060.10	Folden, Deanna	$58,585.36
Drake, Chantelle	73,357.44	Foster, MaryAnne	80,719.88
Draude, Pattie	90,246.45	Francais, Maureen	62,724.08
Duerksen, Loretta J	87,641.24	Franke, Vera	69,392.13
Dumitrascu, Maria	53,487.59	Franklin, Judy	68,482.37
Dyck, Stephanie	68,837.57	Franklin, Karri	106,541.28
Edstrom, Darlene	79,169.97	Freedman, Allison	57,662.06
Edwards, Shelly	91,687.13	Friesen, Dwayne	75,241.24
Enge, Terry	69,656.82	Frisky, Sharon	112,224.11
Ens, Cheryl	62,406.60	Fritshaw, Brittany	67,318.74
Ens, Evan	82,049.79	Froese, Margaret	51,802.19
Epino, Adelfa	51,849.53	Fullerton, Natasha	69,496.56
Erickson, Bonnie	50,172.48	Gallays, Paulette	100,122.74
Ericson, Rayleen	52,487.45	Galucan, Carolyn	102,693.46
Ernst, RaeAnn	79,910.36	Garchinski, Kimberley	102,194.55
Espenant, Rodney	99,648.09	Garland, Stephanie	93,212.42
Ewen, Linda	61,453.11	Geck, Denise	53,881.52
Ewen, Sandy	75,805.22	Genik, Heather	102,236.31
Fagnou, BettyLou	92,704.92	George, Myrna	64,239.29
Fannon, Lee Ann	82,744.32	George-Fairbairn, Jeanne	91,756.70
Farber, Tracy	112,444.02	Getachew, Eyoueal	66,606.51
Farrow, Tracy	50,635.92	Glaves, Connie	118,091.78
Fawcett, Jeffrey	86,953.86	Glister, Sherrie	67,970.23
Fawcett, Stephanie	68,238.23	Gooliaff, Dolores	75,946.94
Fawcett Parkman, Carol	53,268.27	Gordon, Ardis	68,765.95
Fehr, Candice	53,207.32	Gray, Raymond	50,760.31
Fellman, Leanne	95,021.40	Grona, Daniel	54,492.81
Ferguson, Heather	78,425.04	Gudnason, Douglas	102,105.20
Ferre, Arien	76,068.85	Hage, Barbara	77,818.63
Fidyk, Melanie	102,201.57	Hagen, Maureen	101,638.61
Fielder, Jessica	88,164.38	Hainstock, Donna	74,547.23

Hall, Judy	51,367.44
Hall, Michelle	68,410.06
Halvorsen, Elaine	$100,445.63
Hampton, Bonnie	105,333.73
Hanaback, Kimberly	51,753.72
Hancock, Jason	76,324.49
Hancock, Tracie	61,192.20
Hanson, Candice	83,073.95
Harbicht, Faye	77,405.72
Harris, Marilyn	50,053.62
Hart, Sandra	58,919.40
Haugo, Aline	73,870.99
Hayduk, Michael	80,844.66
Hayes, Wendy	88,008.93
Hayward Hunkin, Mickie	60,345.91
Hayworth, Beverly	73,590.04
Heatherington, Breann	61,633.49
Hebert, Caitlin	61,320.15
Hedin, Cody	73,256.73
Hemingson, Linda	101,438.80
Henderson, Elaine	95,851.33
Herbert, Chelsea	96,022.92
Hermus, Joan	86,273.44
Heron, Maureen	67,985.73
Heron, Renee	63,217.96
Hewitt, Anna Dawn	93,643.66
Hiebert, Kari	103,577.65
Hiebert, Shelley	50,193.00
Hildebrand, Leah	62,561.61
Hilkewich, Jocelyn	72,928.53
Hirsch, Jana	86,846.88
Hobbins, Tim	104,840.23
Hoffus, Diane	80,632.57
Hoffus, Kelly	70,712.58
Hoffus, Marianna	93,404.03
Honoway, Sean	$95,905.37
Hooge, Melissa	81,628.41
Horvath, Ashley	56,458.23
Howse, Wendy	76,758.27
Hoyt, Catherine	50,904.38
Hrenkiw, Collette	54,717.17
Hrychuk, Michelle	76,749.00
Hudak, Darlene	67,131.04
Huff, Ashley	58,648.55
Hughes, Tracy	89,209.63
Hunt, Shirley	91,064.37
Hunt, Stacey	92,727.05
Ives, Brenda	77,313.90
Jackson, Vanessa	68,413.08
Janzen, Crystal	82,049.84
Jeffrey, Audrey	70,791.70
Johnson, Bonnie	99,733.43
Johnson, Marilyn	51,160.43
Jones, Judy	72,006.01
Kapeller, Eliza	56,503.71
Keeping, Ruth	74,098.39
Kehrig, Beverly	94,044.79
Khan, Mohammad	223,789.23
Kiefer, Marilyn	116,672.87
Kinch, Derek	52,340.35
Kirk, Wendy	65,075.55
Kirkland, Sherrie	98,519.55
Kisilowski, Laurie	53,153.24
Kiteley, Wanda	65,881.61
Kjelshus, Leslie	59,898.20
Klassen, Linda	55,965.64

Kleiboer, Sharon	68,651.55	Lindsay, Lynda	88,712.08
Knudsen, Irene	77,803.81	Lindsay, Maureen	65,054.27
Knudtson, Shirley	$70,809.34	Lipka, Sharon	$51,516.62
Kolodinsky, Charleen	56,182.96	Little, David	82,049.84
Kolybaba, Amanda	64,183.07	Litzenberger, Joan	94,693.86
Koroll, Jarod	80,177.74	Logan, Kim	106,586.50
Kosokowsky, Louise	67,040.52	Love, Nicolette	88,610.67
Kovach, Tammy	106,185.22	Lueken, Linda	96,656.14
Kovacs, Coral	93,691.96	Lundy, Jody	70,110.88
Kowal, Joell	68,182.12	Lungull, Ervin	72,771.52
Kowal, Louise	85,453.65	MacDonald, Judy	63,748.43
Kowalyk, Leah	64,063.66	Mackie, Carmen	81,444.39
Kozak, Glen	270,122.75	MacNaughton, Angela	51,011.37
Kozun, Tamara	54,328.54	Mahon, Sherry	89,860.41
Kuhberg, Sylvia	60,429.64	Mahussier, Wanda	90,556.89
Kutnikoff, Sarah	77,201.81	Major, Lisa	125,906.58
Kwasney, Laurie	112,585.30	Malhi, Sukhwinde	50,172.48
Lacheur, Debra	56,182.95	Mamer, Francoise	115,609.39
Lalonde, Deborah	88,407.53	Manavalan Antony, Reji	68,348.77
Lamont, Audrey	69,533.02	Mansiere, Shaye	71,813.13
Larsen, Angela	57,406.63	Marban, Charlemagne	123,014.64
Larson, Janelle	82,441.56	Marchildon, Marianne	94,575.43
Le Bras, Doreen	68,143.80	Marshak, Audrey	53,152.23
Le Grand, Mildred	56,182.96	Martens, Heather	62,167.47
Lechler, Pamela	59,868.42	Martens, Lesley	65,013.89
Lee, Joanne	51,584.25	Martin, Kade	74,690.37
Lee, Roxanne	81,822.37	Martin, Pauline	99,432.33
Lee, Susan	76,248.69	Matiasz, Tammy	77,567.95
Leek, Brenda	70,027.95	Mayerle, Alyza	66,750.18
Leepart, Beverly	66,155.11	McCleary, Angela	69,777.22
Lepine, Crystal	60,798.41	McCleary, Patricia	83,968.86
Lindal, Karen	73,256.07	McCorriston, Elizabeth	67,333.62
Lindsay, Joanne	57,065.53	McCorriston, Heather	50,024.98

McCreadie, Stacey	87,222.76	Nagano, Marlene	121,407.86
McCuaig, Chester	90,259.85	Nagano, Myla	67,906.87
McEwen, Stacie	$69,512.02	Nagy, Garnet	$82,934.48
McFarlane, Lana	69,448.26	Nagy, Stacey	66,937.07
McKay, Pamela	237,456.99	Nanaquewetung, Lesley	67,530.76
McKenzie, Trisha	79,168.53	Natomagan, Allana	94,470.21
McKnight, Heather	69,525.56	Neigel, Cindy	83,094.26
McLean, Cheryl	97,622.82	Neigel, Sarah	85,909.70
McLean, Kacy Jae	66,654.75	Neiszner, Tanya	71,855.28
McRae, Sherrie	72,786.38	Nelson, Michele	68,742.78
McWillie, Greg	118,091.78	Neu, Monica	68,356.61
Melrose, Beverly	69,768.38	Neufeld, Anjie	83,094.22
Menzies, Annette	69,845.44	Newbery, Donna	50,179.68
Merriman, Shane	257,678.80	Nickel, Rhonda	113,641.72
Messner, Janice	107,561.63	Nicklefork, Ryan	53,988.66
Mevel Degerness, Nadine	112,415.28	Nontell, Margaret	63,921.39
Meyer, Kathleen	86,252.32	Nordmarken, Kimberly	52,348.20
Meyers, Candace	72,371.14	Nygaard, Sarah	68,581.59
Meyers, Stacey	87,515.92	Nyirenda, Julien	107,487.93
Miller, Heather	91,064.38	O'Flanagan, Cheryl	63,312.18
Miller, Margaret	96,479.39	O'Flanagan, Linda	50,135.97
Misskey, Lisa	86,790.63	Oftebro, Marilyn	52,439.41
Mitchell, Trent	118,091.76	Ollinger, Mark	91,064.37
Mlazgar, Sherry	82,245.49	Ollinger, Monique	88,876.53
Molnar, Kevin	66,697.58	Olsen, Crystal	83,468.96
Molnar, Pamela	94,556.30	Olson, Dinah	80,433.29
Moneta, Shari	71,064.61	Olson, Patricia	111,216.71
Morrow, Irene	64,600.57	Orobko, Laura	56,753.11
Moulton, Tanya	102,065.58	Palaniuk, Carla	84,480.50
Musselman, Leanne	57,128.94	Parlee, Tammy	102,168.45
Mutimer, Candice	50,186.09	Paskell, Darla	51,500.98
Mutimer, Chrystan	50,354.85	Patenaude, Elaine	71,441.35
Naber, Colleen	103,233.39	Patenaude, Judy	72,010.82

Patterson, Dale	66,148.91	Runn, Diane	93,506.96
Patterson, Trudy	50,808.99	Rutherford, Shelley	66,360.23
Pederson, Patricia	$56,993.13	Ryhorchuk, Mabel	$89,651.89
Penner, Shelley	56,572.08	Sales, Josie	99,834.41
Perrault, Linda	103,581.28	Samida, Lorie	72,976.09
Perrault, Roxanne	81,495.89	Sauer, Teresa	51,588.01
Peters, Richard	139,044.43	Scarf, Jeannette	100,223.06
Peters, Sharon	102,768.82	Scheidl, Carol	99,426.11
Peterson, Linda	91,064.33	Scheidl, Leonard	81,391.39
Peterson, Sheryn	58,259.05	Schell, Wendy	90,081.72
Philipation, Ryan	93,814.16	Schidlowsky, Patti	92,589.89
Phillips, Angela	56,182.96	Schmaltz, Carlene	94,255.28
Pieterse, Sandra	114,858.45	Schmitt, Joyce	70,826.00
Pohl, Christine	112,415.31	Schuler, Marijane	72,498.43
Pohl, Curtis	88,246.49	Scutchings, Jodie	93,964.11
Pohl, Jennifer	65,138.03	Sealey, Alisa	87,298.50
Pratt, Laureen	72,409.99	Seck, Emily	51,839.91
Prefontaine, Holly	53,250.86	Seiferling, Sheila	109,515.60
Ratcliffe, Peggy	81,421.09	Senecal, Jean	84,827.07
Ratzlaff, Lyndsay	50,172.48	Serhan, Debbie	68,376.24
Reed, Lorry	93,387.94	Settee, Amy	66,829.91
Reid, Barbara	71,124.25	Shearer, Connie	86,774.57
Reid, Jill	80,837.33	Shiels, Patricia	54,732.59
Riemer, Christina	92,700.69	Shreve, Lisa	71,113.64
Robertson, Rita	81,957.40	Siddons, Sandra	56,182.96
Robin, Rosanne	61,829.98	Simoneau, Renee	92,948.45
Rogers, Candace	75,313.48	Simonson, Wendy	57,549.37
Romaniuk, Trina	78,056.61	Sisson, Maxine	50,172.48
Romanow, Jodi	102,194.56	Skilliter, Dianne	95,925.54
Rosas, Joy Basilisa	72,461.21	Slobodzian, Fred	123,159.23
Rosencrans, Randi	81,027.63	Smears, Wanda	68,705.73
Rudachyk, Betty	60,846.19	Smith, Brooke	95,470.36
Rudychuk, Margaret	101,942.25	Smith, Diane	85,451.17

Sochaski, Linda	51,308.23	Terry, Douglas	109,515.52
Solsten, Julie	92,948.42	Thevenot, Karen	65,970.70
Soonias, Myrna	$63,921.40	Thibodeau, Terry	$70,353.76
Sorestad, Tracy	58,617.66	Thiessen, Corey	65,514.25
Soulier, Avalene	99,471.40	Thompson, Tammy	63,921.40
Sprackman, Michelle	102,194.55	Tosh, Lee	91,064.37
Spratt, Coralie	54,807.51	Townsend, Lorna	55,505.34
Stadnek, Sonja	92,830.53	Toy, Yong	61,812.95
Steadman, Jessica	50,205.82	Trombley, Christine	69,302.36
Stensrud, Colleen	132,601.14	Tung, Tony	68,558.92
Stevenson, Barbara	97,428.09	Uhryn, Chantel	84,686.35
Stevenson, Cheryl	75,688.49	Unger, Catherine	103,480.70
Stevenson, Kathleen	95,112.59	Unruh, Lindsay	71,381.63
Stewart, Geoff	71,695.57	Valeroso, Merla	50,863.16
Street, Faye	94,461.96	VanCamp, Jackie	67,351.39
Streeton, Patricia	94,511.78	Vandertweel, Barbara	78,986.01
Stroeder, Kellie	106,752.47	Vandeveen, Gloria	75,371.31
Stroeder, Kyle	76,367.31	Verklan, Louise	102,194.55
Stuart, Nikki	80,502.18	Walker, Cristen	72,355.47
Sturby, Heather	78,028.19	Wall, Christa	63,921.40
Styan, Cathy	63,921.39	Wallington, Julia	57,209.20
Sullivan, Norinne	80,340.05	Walter, Darin	118,942.92
Sundelin, Jacquelin	64,922.00	Warkentin, Ruth	52,628.95
Sutherland, Melissa	64,497.38	Warner, Bessie	112,415.30
Swider, Darcy	51,377.77	Warriner, Valerie	146,069.95
Syrenne, Sharon	54,324.27	Wassill, Pamela	59,125.37
Szucs, Denise	52,124.10	Watson, Jennifer	73,940.84
Tatarynovich, Emily	65,426.60	Watt, Anita	102,194.55
Tatarynovich, Mary	104,276.67	Wehrkamp, Mary Jane	51,377.76
Taylor, Etta	66,944.68	Weiman, Blair	89,111.36
Taylor, Tammy	52,889.57	Weseen, Sandra	114,697.08
Teichreb, Rhonda	53,629.35	Wesnoski, Barbara	95,797.47
Telawsky, Christine	86,322.67	White, Dale	92,653.79

White, Dayna	50,378.24	Yackel, Twila	105,509.58
White, Tanya	55,772.79	Yaholnitsky, Pearl	$100,780.00
Whitehead, Merna	$71,669.15	Yaremy, Carol	53,925.14
Wicks, Wendy	50,657.25	Yeo, Charles	91,064.37
Wiebe, Crystal	91,478.34	Ylioja, Kim	56,005.64
Wiebe, Helen	100,078.43	Youzwa, Sandee	86,915.95
Wilson, Cheri	89,762.56	Zacarias, Nelson	80,229.49
Wilson, Colleen	52,064.99	Zens, Arlene	112,415.31
Wilson, Doris	95,474.59	Zip, Leanne	54,708.27
Worsley, Rose Kathleen	80,162.26	Zuck, Paul	52,896.93
Wozniak, Deborah	74,663.23		

Transfers

Listed, by program, are transfers to recipients who received $50,000 or more.

None

Supplier Payments

Listed are payees who received $50,000 or more for the provision of goods and services, including office supplies, communications, contracts and equipment.

3S Health (SAHO)	$3,961,726.23	Chitt-Tronics Ltd	116,874.34
AMO Canada Company	161,766.44	City of Melfort	$71,328.98
Archerwill Local # 58	205,214.32	CMC Case Management Canada Inc.	85,101.13
Arjohuntleigh	185,382.21	College of Medicine, U of S	60,250.00
Associate Radiologists of Saskatoon	331,888.59	Covidien	110,512.12
Baxter Corporation	58,394.13	CPDN/RCDP	171,773.48
Beckman Coulter Canada LP	75,208.02	CSI Leasing Canada Ltd	186,697.06
Biomerieux Canada Inc.	97,710.21	CXtec	68,171.28
Caldwell Partners	71,297.07	Diverse Systems Ltd	238,432.70
Cardinal Health Canada	283,674.40	Diversey Canada	77,092.33
Carrot River Medical Clinic Inc.	85,872.00	Dominion Construction Company Inc.	6,119,343.61
CDW Canada Inc.	402,037.98	Dr. Bala Medical Prof. Corp.	281,859.04

Dr. A. Laosebikan	79,315.93	Ecolab Ltd	54,317.55
Dr. Adewole Omolambe	56,421.65	eHealth Saskatchewan	175,102.06
Dr. Albert Albertyn	$91,674.40	Electric Lee Ltd	$173,901.30
Dr. Aleka Smith	243,674.17	Energy Doctor	67,906.96
Dr. Alex Lukubisa	85,962.00	ESBE Scientific Industries Inc.	52,822.95
Dr. Assumpta Efobi	313,944.88	GE Healthcare Canada	288,938.57
Dr. Bronwyn Carroll	254,492.30	Geanel Restaurant Supplies	82,822.59
Dr. Bulelwa Mpisi	319,317.00	Grand & Toy Ltd	73,231.75
Dr. Charles Orhadje	373,277.39	Great West Life	503,418.19
Dr. Dale Peffer	323,234.56	Health Sciences Association of Sask	82,005.03
Dr. Eben Strydom	60,624.59	Honeywell Limited (Calgary)	383,913.31
Dr. Eleanor Francis	332,141.62	Hospira HealthCare Corp.	263,715.95
Dr. Herbert Medical Prof. Corp.	274,410.64	Hudson Bay Medical Group	1,565,581.43
Dr. J. G. Rye	54,296.98	Insight	82,985.64
Dr. Jackson Lekota	91,200.00	Instrumentation Laboratory	105,573.82
Dr. Johann Baard	345,095.07	Johnson & Johnson Inc.	66,669.31
Dr. Jordan Wingate	167,437.50	KCI Medical Canada Inc.	104,138.50
Dr. Juliana Van Jaarsveld	386,218.33	Kelvington Ambulance Care Ltd	421,916.68
Dr. Kayode Olutunfese	158,767.50	Kelvington Medical Clinic	70,033.29
Dr. Mariusz Gurgul	165,616.00	London Life Insurance Company	110,771.00
Dr. Melissa Fillis	266,976.40	Macquarie Equipment Finance Ltd	89,307.90
Dr. Michael Stoll	52,500.40	Maintenance Enforcement Office	65,000.00
Dr. Nelini Reddy	134,915.00	Marsh Canada Limited	220,346.50
Dr. Neville Van Der Merwe	332,308.48	McKesson Canada	236,307.19
Dr. Okezie Nweze	59,194.46	McKesson Distribution Partners	132,322.38
Dr. Oluwafemi Adegboyega Ketiku	196,574.42	Meditek	54,426.12
Dr. Onose A. Lawani	76,132.50	Melfort Ambulance Care Ltd	502,690.76
Dr. Pat Chernesky	250,367.19	Ministry of Central Services	651,629.97
Dr. Pierre Hanekom	78,798.09	Nipawin Flight Center	96,694.50
Dr. Prince Manzini	323,578.32	Nipawin Medical Group	161,800.00
Dr. Rosemarie Tessa Richardson	344,504.60	Nipawin Oasis Community Centre Co-op	53,958.56
Dr.Gemma Nelson	145,347.84	North East EMS	1,020,164.52

North Sask Laundry & Support Services	802,969.84
Olympus Canada Inc.	202,420.54
Ortho-Clinical Diagnostics	$384,727.09
P3A	639,159.05
Paramount Paving Ltd	420,871.50
Parkland Ambulance Care Ltd	134,749.26
Philips Healthcare	282,966.76
Prairie North Co-opative Association	54,847.26
PA Parkland Regional Health Authority	72,395.05
Public Employees Superannuation Plan	68,422.47
QHR Software Inc.	67,829.40
Ricoh Canada Inc.	65,038.60
Roche Diagnostics	60,310.26
Saputo Foods Limited	129,534.30
Sask Energy	1,174,212.71
Sask Power	1,207,813.13
Sask Tel	750,759.96
Sask Workers Compensation Board	1,013,304.05
Sask Government Employees Union	1,293,330.82
Sask Healthcare Employees Pension Plan	11,417,441.42
Sask Registered Nurses Association	131,197.50
Saskatchewan Union of Nurses	343,973.77
Saskatoon Regional Health Authority	341,271.31
Saskworks Venture Fund Inc.	$54,632.00
Schaan Healthcare Products	1,194,019.56
Select Medical Connections Ltd	170,083.05
Shamrock Ambulance Care Ltd	233,892.12
Siemens Healthcare Diagnostics Ltd	264,778.68
Solutions Staffing Inc.	78,502.01
Sorin Group Canada Inc.	51,259.90
Stevens Company Limited	251,221.53
Stryker Canada	112,013.76
Sun Life Financial	59,324.93
Sysco Food Services	1,306,198.61
Tisdale Ambulance Care Ltd	492,292.06
Toshiba Business Solutions	107,351.30
Town of Naicam	137,457.24
Town of Nipawin	85,033.68
Town of Tisdale	62,790.45
Van Houtte Coffee Services Inc.	73,741.11
Vitalaire	65,131.59
WBM Office Systems	79,058.73
Wood Wyant Inc.	256,697.50

Sources

Government of Saskatchewan. *Ministry of Health Plan for 2013-14*. Available at: http://www.finance.gov.sk.ca/PlanningAndReporting/2013-14/HealthPlan1314.pdf

Government of Saskatchewan. *Saskatchewan Plan for Growth: Vision 2020 and Beyond*. Available at: http://www.gov.sk.ca/adx/aspx/adxGetMedia.aspx?DocID=3975,594,1,Documents&MediaID=4745&Filename=Saskatchewan+Plan+for+Growth+-+Full+Version.pdf

Saskatchewan Ministry of Health. *Patient- and Family-centred Care in Saskatchewan: A Framework for Putting Patients and Families First.* June 28, 2011. Available at: http://www.health.gov.sk.ca/pfcc-framework

Patient First Review Commissioner's Report to the Saskatchewan Minister of Health. *For Patients' Sake.* October 2009. Available at: http://www.health.gov.sk.ca/patient-first-commissioners-report

Saskatchewan Ministry of Health. *Sooner, Safer, Smarter: A Plan to Transform the Surgical Patient Experience.* March 2010. Available at: http://www.health.gov.sk.ca/adx/aspx/adxGetMedia.aspx?DocID=545d9e1d-6cfe-447d-ac42-3b35f0dc8f5d&MediaID=3706&Filename=surgical-initiative-plan-mar-2010.pdf&l=English

Saskatchewan Ministry of Health. *Patient Centred, Community Designed, Team Delivered: A framework for achieving a high performing primary health care system in Saskatchewan.* Available at: http://www.health.gov.sk.ca/phc-framework-report

Saskatchewan Ministry of Health. *Saskatchewan's HIV Strategy 2010-2014.* November 2010. Available at: http://www.health.gov.sk.ca/phc-framework-report

Accreditation Canada. Available at: http://www.accreditation.ca/

Canadian Standards Association. Available at: http://www.csagroup.org/ca/en/services/codes-and-standards

Safety Healthcare *Now*! Available at: http://www.saferhealthcarenow.ca/EN/Pages/default.aspx

Saskatchewan Ministry of Health. 2012.*Covered Population 2013.* Available at: http://www.health.gov.sk.ca/covered-population-2013

North East Regional Intersectoral Committee. *Northeast Housing Research Project: Housing Strengths and Gaps in Melfort, Nipawin, and Tisdale.* March 2010. Available at http://www.northeastric.ca/publications/Northeast%20Housing%20Research%20Project%20Final%20Report.pdf

Saskatchewan Food Costing Task Group. *The Cost of Healthy Eating in Saskatchewan 2012.* *http://www.kelseytrailhealth.ca/Publications/ProvPubs/Documents/The%20Cost%20of%20Healthy%20Eating%20in%20Saskatchewan%202012.pdf*

Indigineous Peoples' Health Research Centre. 2006. *Mino-Mahcihowin A Report on Indigenous Health in Saskatchewan: Report of the Indigenous Peoples' Health Research Centre.* Available at http://iphrc.ca/assets/Documents/Miyo-Mahcihowin.pdf

Statistics Canada. 2013. *Kelsey Trail Regional Health Authority (Health Region), Saskatchewan and Saskatchewan (table). Health Profile. Statistics Canada* Catalogue no. 82-228-XWE. Ottawa. Released December 12, 2013. *http://www12.statcan.gc.ca/health-sante/82-228/index.cfm?Lang=E (accessed June 4, 2014)*

Saskatchewan Cancer Agency. *Cancer Control Report 2004.* Available at: http://www.saskcancer.ca/adx/aspx/adxGetMedia.aspx?DocID=94,5,1,Documents&MediaID=a2d34e95-cfb9-48bc-8948-c0f97f7469b5&Filename=SCCR+2004.pdf

Canadian Cancer Society's Advisory Committee on Cancer Statistics. *Canadian Cancer Statistics 2013.* Toronto, ON: Canadian Cancer Society; 2013. Available at: http://www.cancer.ca/~/media/cancer.ca/CW/cancer%20information/cancer%20101/Canadian%20cancer%20statistics/canadian-cancer-statistics-2013-EN.pdf

Saskatchewan Ministry of Health. Community Care Branch. *Community Program Profile 2012-13.*

Saskatchewan Health Quality Council. 2014. *Quality Insight.* Available at http://www.qualityinsight.ca/indicators

For More Information

For further information relevant to the Kelsey Trail Health Region, contact Regional Office at (306)873-6600 or visit the following website:

Kelsey Trail Health Region
http://ww.kelseytrailhealth.ca/

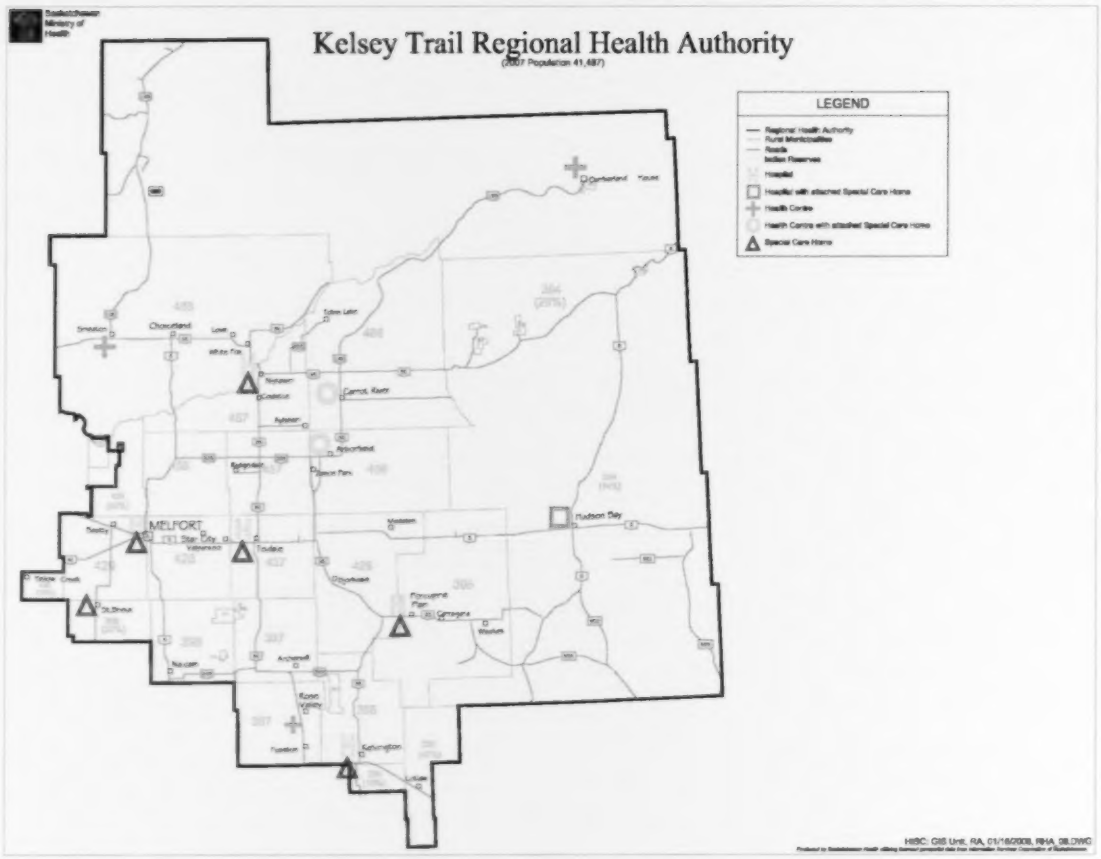
KTHR By The Numbers

During the 2013-14 fiscal year, KTHR reported:

- 3,276 acute care admissions
- 21,937 patient days
- 54,942 ER visits
- 223 births
- 291 dialysis patients
- 232 long term care admission
- 165,799 long term care resident days
- 25,441 home care clients
- 2,268 occupational therapy visits
- 1,352 physical therapy visits
- 3,901 exercise therapy visits
- 417 speech language therapy visits
- 720 mental health clients and 7,352 mental health visits
- 385 addiction clients and 3,340 addiction client visits

Did You Know?

- ✓ Approximately 480 residents call KTHR long term care facilities their home.
  - Thirty-four residents are under the age of 65 years.
  - Twelve residents are over 100 years old.
- ✓ For the first time in several years, KTHR reached its full complement of physicians in 2013-14.
  - Nine new physicians were recruited to KTHR this year.
- ✓ In total, 163 new employees were hired to KTHR in 2013-14
  - Support Services – 67
  - Continuing Care Aides – 58
  - Registered Nurses - 23
  - Health Sciences – 7
  - Licensed Practical Nurses – 6
  - Management – 2



Kelsey Trail Health Region

Regional Office
901-108th Avenue
Tisdale, SK S0E 1T0

Phone: 306-873-6600
Fax: 306-873-6605
www.kelseytrailhealth.ca